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The Journal of Cutaneous Diseases

INCLUDING SYPHILIS

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INCLUDING SYPHILIS

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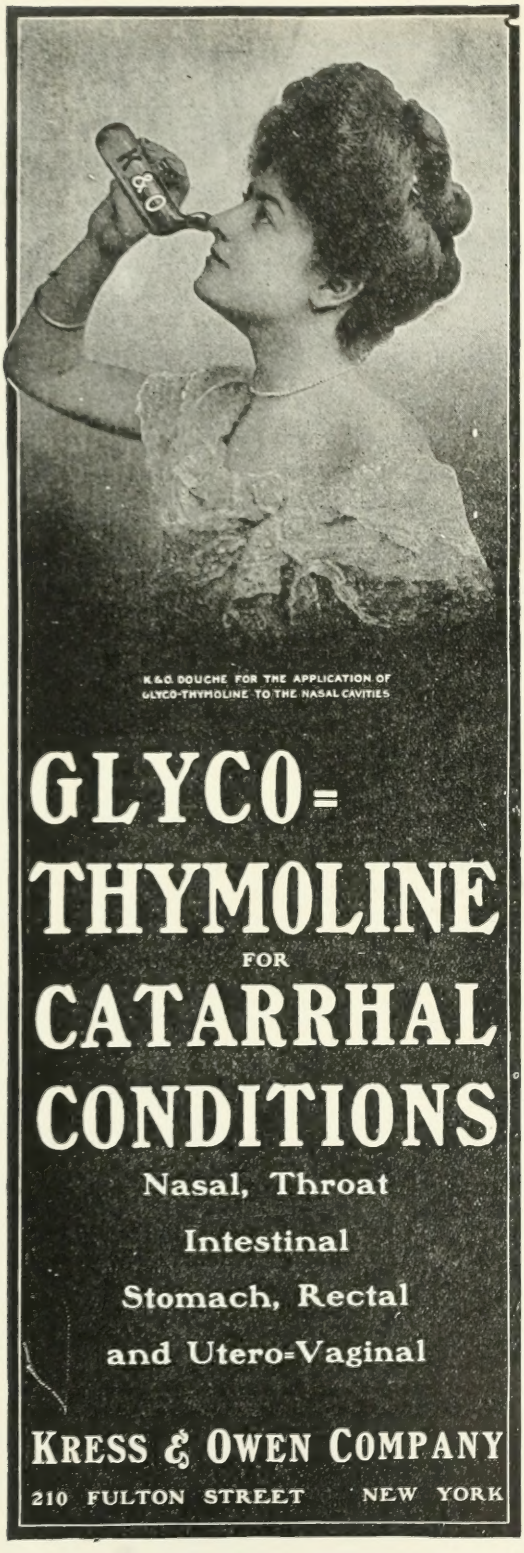

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THE JOURNAL OF CUTANEOUS DISEASES

VOL. XXVI. JULY, 1908. No. 7

DERMOLYSIS — AN UNDESCRIBED DISSOLUTION OF THE SKIN.

By CHARLES J. WHITE, M. D., Instructor of Dermatology in Harvard University.

ON February 21, 1908, a man was referred to the Skin Department of the Massachusetts General Hospital from the Orthopædic Room, where he was being treated for an acute synovitis of the knee.

This man was born in Russia twenty-five years ago, and has worked in a bakery for years. His history may be unreliable although obtained at his two visits through the interpretation of two different well educated medical compatriots, but the man was hopelessly indifferent and totally uninterested in his cutaneous disease which caused him neither pain nor mortification.

About ten years ago the man was apprenticed to a baker in Russia and following the custom of the country was obliged, during the eighteen months of his apprenticeship, to sleep with his companions in a low-ceiled room on top of the heated brick and mortar oven. Since that time he has continued his occupation of baking, but now enjoys a more hygienic bed.

The first lesions of his present dermatosis are said to have developed during, or shortly after, his apprenticeship, but judging from appearances, certain lesions are of a much more recent date. The patient thought that possibly some of the early nodules might have disappeared, but no corresponding scar tissues or atrophic points could be found. There were apparently no subjective symptoms and firm pressure could produce no signs of pain. The process was limited to the elbows and to the supra-patellar regions of the thighs. There were many nodules on the right elbow and on the left thigh, while the corresponding sites of the other limbs were but scantily affected.

The lesions varied from three to ten millimeters in diameter. The early papules were of a cherry color, round, dome-shaped, firm and rather tense and freely moveable in the skin. Younger lesions

were about four millimeters in diameter, round, flat or even depressed on top, muddy white in color and softer than their younger companions. Both of these varieties were comparatively sparse, but isolated and appearing without any fixed relation to the more conspicuous elements of the disease, that is, some had developed at the periphery of the affected areas and some in the center between the lesions about to be described. The youngest lesions, most striking because of their relative numbers, size and formation were approximately ten millimeters in long diameter and were composed of peripherally set, contiguous but distinct, flat-topped, muddy white, softish papules, one and one-half millimeters in diameter, arranged in an oval or circle around a central, blue-red, relatively sunken, velvety skin. This contrast in color was most evident when the skin over the nodules was put on the stretch and then in a way the whole arrangement suggested a sapphire brooch surrounded by pearls.

No suggestion whatever of suppuration was discernible in any existing lesion and as stated above no evidence of cicatricial or atrophic tissue could be found, unless one is to regard the central blue-red portion of the oldest lesions as evidence of atrophy. In other words, the evolution of the disease seemed to be peculiarly sluggish and this quality was manifested only by the further growth in extent of the more mature simple and compound lesions, accompanied by loss of color, refraction and density. Pricking of several of the lesions of all varieties with a large needle followed by firm pressure produced nothing but a droplet of dark blood and this procedure seemed to be rather strikingly painless.

With such data at hand what possible diagnosis could be made?

1. Adenoma sebaceum seemed improbable on account of the seat of the disease and on account of the size of the older lesions and their gradual tendency toward flatness and grayness of tone.

2. Benign cystic epithelioma in all its various pathological subdivisions seemed unlikely, because of the position of the lesions and their progressive change in consistency and hue.

3. Colloid degeneration, although so rare an affection, was considered a decided probability in many ways, but the hitherto unrecorded site of the process (all previous cases being associated with exposed parts), the absence of the characteristic translucent, orange-yellow color, the age of the patient, and the failure to squeeze the usual jelly-like mass from the pricked papules obliged one to defer

the possibility of a final decision until after the microscopic examination.

4. Degeneration of elastin is often observed histologically in connection with various cutaneous diseases (lupus erythematosus, X-ray dermatitis, senility, scars, etc.), but usually the preponderating dermatosis determines the clinical aspects of the case. Dreuw (*Monatsh. f. Prakt. Derm.*, Vol. 36, p. 629), however, once described an instance where this selective degeneration was the only pathological factor present, but in his case the degeneration produced clinically confluent crusts on a reddened, swollen, ulcerated base and therefore such a conception was impossible in the present instance.

5. Leiomyoma appeared doubtful, because the situation of the process was unusual, because the frequent characteristic symptom of paroxysmal pain was absent and because the older growths were muddy white in color.

6. All forms of lichen could be ruled out probably on account of the duration of the malady and the absence of pruritus.

7. Lymphangioma tuberosum multiplex (Kaposi) has hitherto been associated with the trunk, but the final decision on this point was deferred until the histological details were made known.

8. The "multiple and benign tumor-like growths" pictured by Schweninger and Buzzi (*Internat. Atlas of Rare Skin Dis.*, part 5), were white, but they appeared on the shoulders, back and thighs and underwent an atrophic evolution, followed by scars [and the loss of elastic tissue microscopically]. Therefore, this idea was untenable.

9. Pseudo-xanthome élastique, described by Darier, consisted of light gray or yellowish papules, non-infiltrated, just jutting above the skin and associated with the later stages of phthisis pulmonalis. [Histologically characterized by prominent granular masses of elastin (an elastoma) in the upper or middle corium and accompanied by giant cells]. Again an impossible diagnosis in the present case.

10. Sarcoids could be clinically discarded because of the long continuation of the process and the color properties of the older lesions. [Histologically by the absence of the characteristic cellular invasions].

11. Sarcoma of all varieties were not to be thought of on account of the benignity of the disease and the gray coloration and flattened surface of the mature lesions.

12. All of the smaller type tuberculides could be excluded by the total lack of necrotic degeneration and marked atrophic or cicatricial sequelæ.

13. Xanthomata of any type could be eliminated by the absence of the pathognomonic yellow or red and yellow lesions. [Histologically because none of the peculiar giant cells were present].

Most of the above diagnostic possibilties were considered during the examination of the man, and he was afterwards presented to the Boston Dermatological Society, but after a full discussion of the case, no member wished to hazard a definite opinion.

Fortunately, the man consented to a biopsy, and at his first visit a young pink nodule from the arm was excised.

HISTOPATHOLOGY

The specimen was cut in three pieces, hardened in Zenker's fluid and imbedded and cut in paraffin.

Mallory's Hæmatoxylin-phosphotungstic acid.

A series of eight sections was stained by this method.

Epidermis. Stratum spinosum. The palisade layer was well differentiated, the cells assuming the normal vertical position, although perhaps rather longer than usual. The lower boundary was in places continuous and sharply separated from the corium, while in others the line of demarcation was indistinct and interrupted. The rete proper presented numerous deviations from the normal. The lower half of the layer was composed of polygonal cells, whose nuclei were vesicular and very large, occupying most of the cell contents. The nuclear protoplasm was very scanty, containing but little substance beyond a well marked nucleolus and several granules of chromatin. Occasional mitoses were seen. The intercellular spaces were very narrow, the cells being practically contiguous, but retaining their spines. Here and there nuclei had disappeared, leaving vacuoles. The upper half of the rete was composed of horizontally-lying cells, for the most part minus their nuclei; but there was no vacuolization, the protoplasm closing in and filling the space formerly occupied by the nucleus.

The stratum granulosum was absent entirely. There was no

suggestion of granular cells or even of granules, in fact, the layer could be properly described as non-existent.

The stratum corneum was present and exhibited no noteworthy abnormalities.

Corium. Papillæ were not numerous or as elongated as would be expected in this region of the body. Consequently, papillary vessels were rather inconspicuous, but when present appeared sufficiently normal. Subpapillary vessels were even less prominent.

The essential lesion of the disease could be best described as a rarefaction of the corium from the subpapillary layer downwards. This change seemed to be comparatively sharply demarcated laterally, not by any straight vertical boundary perhaps, but nevertheless the change from the normally abundant, rather dense wavy lateral bundles to the rarefied, broken, delicate, short central fibres was quite abrupt from a vertical point of view. In this abnormal area staining reactions and chemical affinities were apparently normally preserved—collagen and elastin received the acid reagents typically and the epithelial structures likewise absorbed the basic stains unchanged. The disease evidently consisted of a physical alteration—in other words the sections gave the impression that some unknown factor had caused a diminution in the number and size of both the ecto- and ento-dermic structures. Perhaps one might think from a superficial examination of one section that the hardening had not been perfect in this rarefied area of the skin, or that the microtome knife had injured it. So a single section might look to a casual observer but interrupted serial sections from the original three parts of the excised papule disclose this pathological change (and then continuously) only in the middle portion of the papule. The epidermis, however, remains abnormal throughout the whole three portions.

Under oil magnification the abnormal area showed: 1st, normal elastin, less in quantity than normal and each fibril small; 2d, empty lacunæ of irregular shapes and of considerable size; 3rd, lacunæ containing coagulated and reticulated fibrin with occasional free pigment granules in cross and longitudinal sections; 4th, areas where collagen existed as delicate fibrillæ but staining sharply and looking as though it had been "teazed out"; 5th and most prominently, an extensive area of distinctly separated, broken, wavy, short, normally staining collagen with well preserved nuclei; 6th, isolated small groups of sharply tinted lymphocytes, occasional free, somewhat vesicular, often large connective-tissue nuclei, and here and there

a small vessel whose endothelium was emphatically swollen and whose perithelium was invaded by lymphocytes. Thus the whole of this area resembled a hypoplastic structure, the elements of which had been diminished and separated by some physical rather than chemical force.

The more healthy portions of the corium under the highest magnification presented normal collagen and elastin, but also peri- and end-arteritis. These diseased vessels were surrounded by lymphocytes, while their lumen was much encroached upon by endothelial swelling which in some of the smaller branches had advanced to total occlusion of the channel. Such vessels were seen at all levels, but most prominently in the middle and lower strata. Polynuclear cells, mast cells and plasma cells were absent.

In both the abnormal and comparatively normal areas of these eight sections sebaceous and sweat structures were nowhere visible.

HÆMATOXYLIN-EOSIN

In this series of thirty-two sections the extraordinary time needed, even with a very ripe solution, for the hæmatoxylin to penetrate the basic elements was noteworthy. These secretions were from the very heart of the papule and throughout their extent there were many rete cells whose nuclei had shrunk, leaving wizened, distorted figures surrounded by empty halos.

Staining by this method revealed important details apparently too subtle for the phosphotungstic acid to differentiate. Here it was evident that chemical instead of physical changes had been at work in the production of the disease. Throughout the corium there were the same dissociated connective tissue fibres which marked the process in the sections stained by Mallory's method, but here various steps in the possible evolution of the disease could be noted and followed. There were: 1st, numerous disrupted, short, normally staining collagenous bundles and fibres; 2nd, numerous bundles of fibres which received the acid eosin in their inner fibrillæ, while the outer layer absorbed the basic hæmatoxylin, and this was prettily demonstrated in certain spots which resembled induction coils with inner cross-cut normal acid fibrillæ and outer surrounding longitudinal basic strands (This arrangement is unusual. In such instances it is usually the innermost fibres which first undergo this change); 3rd, certain areas, especially prominent in the depth of the sections, where the fibres received the blue stain wholly without any suggestion of the normal acid affinity: 4th, considerable spaces where the constitu-

ents of the corium had dwindled into cloudy, faintly basic-staining meshwork, the exact nature of which was difficult to determine (was it fibrin or was it colloid degeneration?); and 5th, empty lacunæ (the end stage of the process?), some of which contained minute and basic-staining rings, the last remnants of capillaries or sweat glands.

In this series of sections well-preserved sweat glands were observed in the normal portions of the cuts, while muscular bundles could be seen both in the normal and in the abnormal areas.

EOSIN-ALKALINE METHYLIN BLUE

Throughout this series of eight sections nothing further was revealed.

ACID ORCEIN

These seven sections deeply stained with this selective elastic tissue dye present still further interesting details. As a whole this substance is diminished in quantity throughout the entire depth of the corium and is also arranged in a peculiar manner. Below the sub-papillary layer there are long, parallel strata running across the whole section but diminished in quantity in their transit through the area of rarefied and modified collagen. Between these prominent layers the elastic tissue is still further diminished in amount. The parallel strata are also conspicuous on account of their composition and consist of fine, compact, dark-brown, tortuous fibrillæ (elastin) accompanied by coarse, swollen elements much lighter in color and less twisted in form.

We are not confronted here with elacin which absorbs basic-stains for this abnormal substance was not found in the hæmatoxylin-eosin sections, but we are dealing with the rarer substance, collastin, and we have again found in this puzzling dermatosis a constituent of the corium distinctly altered physically and chemically.

With such histological findings in what appeared to be the earliest type of papule it was thought that the examination of the maturer lesions would reveal more conclusively the true nature of this obscure disease. After much bargaining the man consented to a second biopsy and an isolated, muddy-white papule and a section of a compound lesion (including outside normal skin, muddy-white papule and central, velvety, blue, depressed skin) were excised. It must be confessed that these more advanced lesions were expected to demonstrate unquestionably that colloid degeneration was the

cause of this disease, but, unfortunately, the examination of 124 sections from these later excisions revealed positively no greater degree of chemical change.

The histological picture was the same, save that dermal epithelial structures, surrounded by very marked mononuclear cellular invasions, were more in evidence and the disintegration was more pronounced physically both in the muddy-white papule and in the central bluish skin.

In summarizing the results of this rather detailed description, what are the salient points? We find clinically pea-sized, dome-shaped, cherry-colored papules, which apparently evolve into hitherto undescribed flattened, muddy-white lesions, isolated or grouped around a relatively depressed, bluish-red, velvety centre. These features are of long standing, developed originally on non-exposed areas of a boy's skin and have remained unassociated with all subjective symptoms. Histologically we note: conspicuous epidermal changes; endarteritis; peri-vascular, peri-follicular, and peri-glandular lymphocytic infiltration; basophilic collagen; collastin; general diminution of collagen and elastin; and lastly, gradual disappearance of all these structures focally.

In an early part of this paper it was demonstrated that no well recognized dermatosis, with the possible exception of colloid degeneration, could be identified with the present lesions from a clinical point of view, and now that the pathological nature of the present disease has been revealed are we nearer our goal, can we place these baffling lesions in any hitherto recorded niche? I fear not.

A very thorough search through past literature has failed to disclose any exactly similar condition, but, of course, such unexplored paths are poorly blazed and a previous, possibly isolated, unduplicated title may have failed to find its proper place in our dermatological catalogues.

The closest analogues are the following: Graham Little (*Brit. Jour. Derm.*, 1904, p. 137), describes a "number of flat, light cream-colored patches, the largest being 2-3 mm. across, the smallest 1 mm., very slightly raised from the surrounding skin." Later (loc. cit., p. 177), this same author reports that histologically these papules showed "an area immediately below the papillary zone in which the collagen bundles stained differently to the collagen in other parts. It was possible that this indicated a degeneration of the collagen in patches corresponding to the position of the tumors." This case seems to correspond in some ways to the one under dis-

cussion, but Little mentions no rarefaction of the corium and tells but little about the chemical nature of the collagenous metamorphosis.

Dubreuilh (*Annales de Derm. et de Syph.*, 1906, p. 569) relates the history of a woman of forty-four who presented an eruption of nine months' duration accompanied by slight pruritus. The disease began on the forearms and gradually spread over her arms and back, and consisted of follicular pale miliary nodules, ("blanc-mat") slightly yellow, with smooth surface, 1-2 mm., in diameter, very hard and lying in a perfectly normal skin. Eventually these papules coalesced and terminated in scleroderma. Histologically the early nodules presented a peri-follicular rarefaction of the corium, the collagenous bundles of which stained palely. The author gives to this anomalous condition the title "fibromes miliaires folliculaires." Again, we can select certain similarities in the two cases, but we can go no further in trying to harmonize them completely.

Balzer (*La Pratique Dermatologique*, Paris, 1904, vol. 4, p. 794) tells us that microscopically the linear depressed scars which follow pregnancies consist of drawn-out and dissociated collagen and elastin with a relative thickening of these structures in the surrounding normal skin; but once more the similarities in the two processes are limited.

Histological details of senile skin, certain cicatrices and myxœdema (see Unna, *Histopathology of the Diseases of the Skin*, Walker's Translation, 1896, p. 976 et seq., p. 991 et seq., and also Krzysztalowicz, *Monatsh. f. Prak. Derm.*, 1900, vol. 30, p. 265) are analogous to the microscopic details of the present case, but, of course, there can be no questions of these conditions clinically.

And lastly can we reconcile the present dermatosis with our meagre conceptions of colloid degeneration? Undoubtedly the histology of the two processes have many details in common as will be seen from the following quotation from Bosellini (*Annales de Derm. et de Syph.*, 1906, p. 761) "as a stage in the evolution of the disease before arriving at the final product, colloid, we find masses of collastin and finally, perhaps, collacin, represented by the central basophilic substance of the clumps of degenerated collagen . . . That which is never produced is elacin . . . In the colloidal degeneration the alterations affect the cells, although tardily, so that one finds them well preserved and clearly stained around and in the midst of the collagen, but they finally disappear also."

Despite this somewhat parallel histological picture it seems impossible to call the present disease colloid degeneration, for microscopically the disintegration does not terminate in colloid masses but seems to be represented by an utter disappearance of the corium, while clinically the papules appeared in a boy on non-exposed parts and did not present themselves as translucent, orange-colored lesions, from which a jelly-like matter could be expressed.

What, then, is to be the final word concerning this dermatosis which seems to stand without a precedent in our present dermatological literature. As a title I have coined the word dermolysis—a dissolution of the derma—and as histologically in colloid degeneration and often in senile skin we find basophilic collagen, collastin, and a relative persistence of the cellular elements, ætiologically the result of long-continued exposure to the action of light, heat, and possibly cold, so here we find the same chemical microscopic changes due perhaps to the subjection of the skin, during the boy's apprenticeship, to the extraordinary and intimate exposure to heat while sleeping night after night on a glowing oven and, in later years, to the possible further action of heat plus light in the recurring blasts from the open doors of his hot bakers' ovens. And, furthermore, as we note endarteritis in chronic X-ray dermatitis, so here we find a similar pathological change in a skin exposed by habit to intense light and heat.

In conclusion, I wish to thank my colleague, Dr. H. P. Towle, for the photograph which illustrates the clinical features of the case, and especially Mr. L. S. Brown, photomicrographer to the Massachusetts General Hospital, for the really perfect pictures which demonstrate better than my faulty words its interesting microscopical details.

DESCRIPTION OF PLATES

Fig. 1. The macroscopic lesions.

Fig. 2. x75. A dome-shaped, cherry-colored papule. Note the apparent absence of nuclei in the rete; the real absence of granular cells; the focal disintegration of the corium with the relative persistence of cellular elements.

Fig. 3. x1500. A section of the rete. Note the relative increase in size of all the nuclei; the decrease in protoplasm of most of the nuclei; the distortion of some of them; and the total disappearance of others, with final loss of their cell boundaries.

Fig. 4. x310. A central area of the corium where the disintegration is only partial. Note the great decrease in density of the collagen; the lower darker areas of basophilic collagen; the foci where fibrous tissue is reduced to a fine mesh-work; other areas where it has entirely disap-

PLATE XXII. To illustrate Dr. Charles J. White's Article.

Fig. 1.

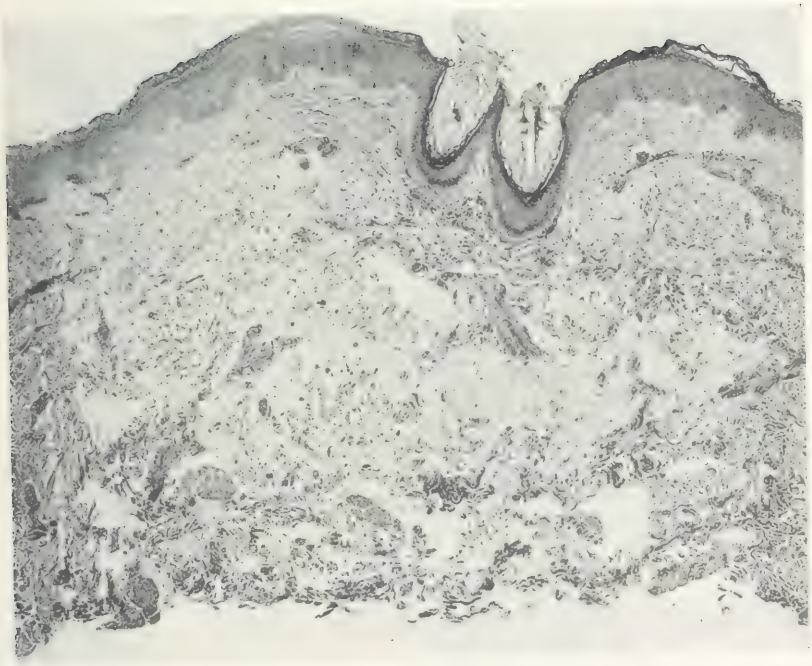

Fig. 2.

PLATE XXIII.—To illustrate Dr. Charles J. White's Article.

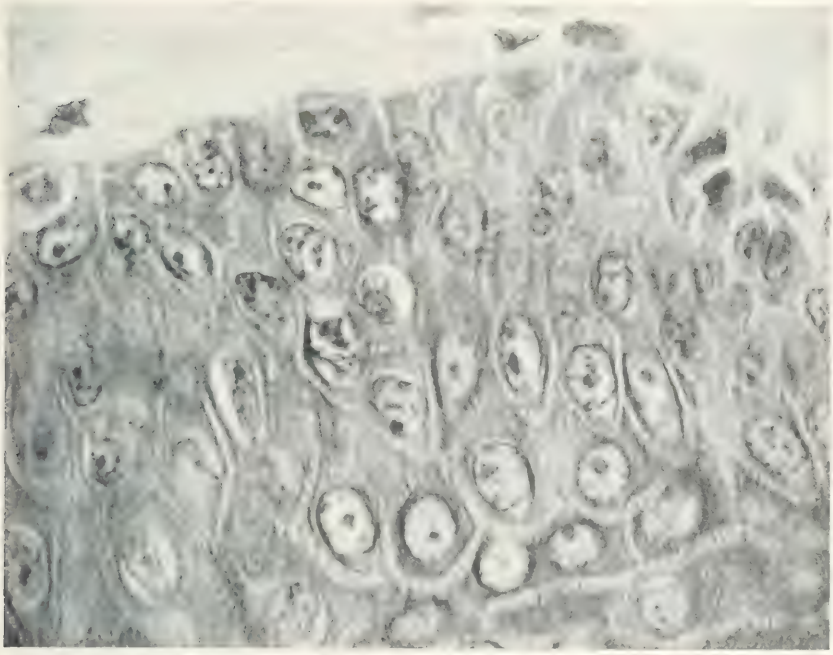

Fig. 3.

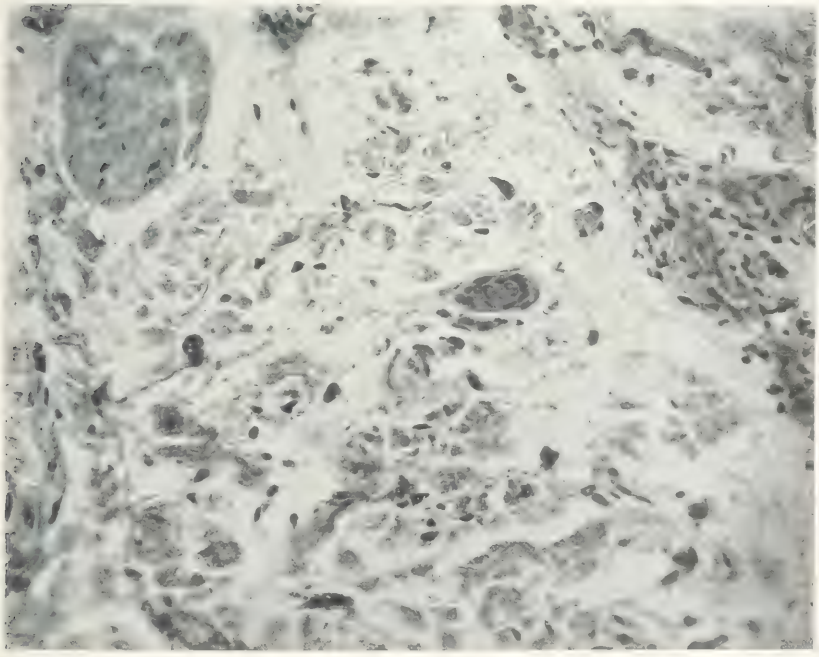

Fig. 4.

PLATE XXIV.—To illustrate Dr. Charles J. White's Article.

Fig. 5.

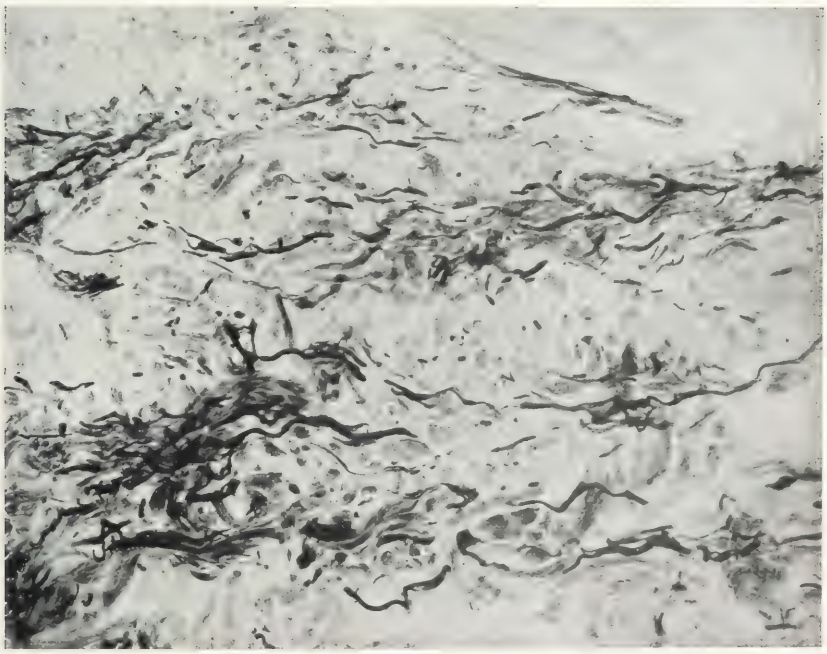

Fig. 6.

PLATE XXV.—To illustrate Dr. Charles J. White's Article.

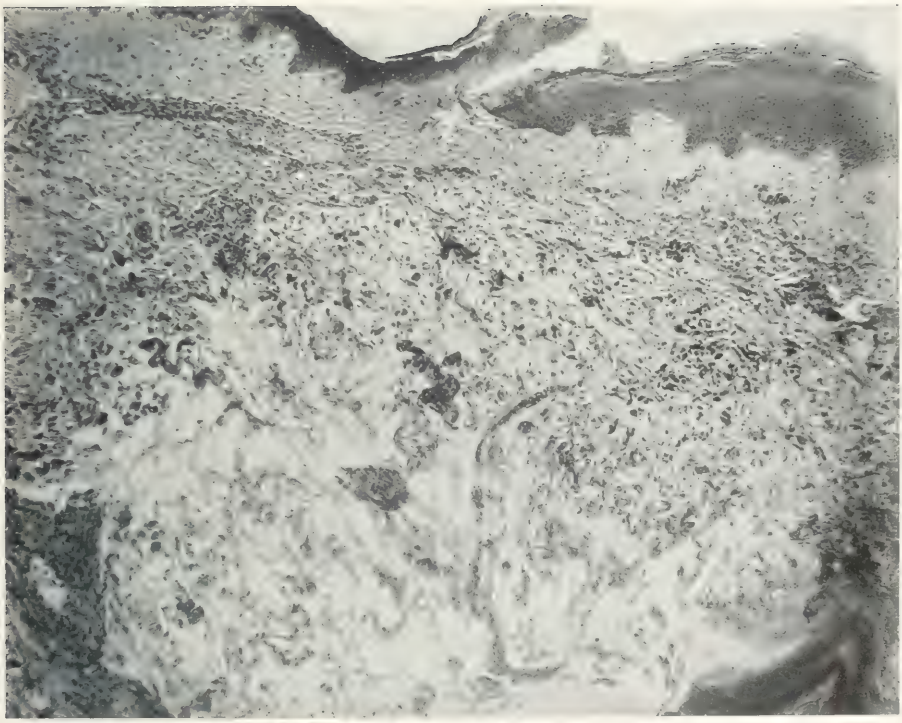

Fig. 7.

peared; the persistence of muscle (upper left corner) and blood vessels with surrounding lymphocytes (upper right corner); and two crystals (upper middle), which Unna refers to in connection with myxœdema.

Fig. 5. x1500. The depth of the corium, demonstrating the basophilic collagen, and the great disintegration of the area. The lighter parts of the tissue are the normal acidophilic fibrils; the darker portions are the abnormal basophilic fibrils. Note in the center the induction-coil arrangement of the fibrous tissue with the central cross-cut eosin particles and the outer longitudinal hæmatoxylin fibres. This primary external degeneration is contrary to the experience of Unna and others.

Fig. 6. x310. The middle strata of the better preserved portions of the corium, illustrating most clearly the normal faintly tinged collagen, the black-brown, clear-cut fibres of elastin, and the rare, swollen, less tortuous, pale brown accompanying masses of collastin. Note also the unusual stratification of the elastic elements.

Fig. 7. x75. Section of the relatively depressed bluish center of the compound lesion. Note the much more advanced dissolution of the corium, the swollen, partly basophilic collagen, and the comparative resistance of the enclosed epithelial elements.

ICHTHYOSIS OR ACANTHOSIS—WHICH?

By W. W. Roblee, M. D., Riverside, Cal.

A Further Report on the Case Reported as Ichthyosis of Unusual Location, in the *Journal of Cutaneous Diseases*, July, 1907.

THE patient, acting upon advice received from his attending physician, removed to Southern California in the spring of 1907, and has been under the care of my associate, Dr. A. S. Parker and myself since that time. The present condition is as follows:

The face is darker than that of the average person, appearing to be deeply tanned, as if it had suffered long exposure to the sun; it is studded with numerous pigmented moles and warts. The skin about the inner folds of the lower eyelids is somewhat thickened, and a pigmented area surrounds the eyes. There is a slight thickening of the skin about the angles of the mouth. The skin of the neck, axillæ, region of the nipples, the abdomen above and below the umbilicus, the flexor surface of both arms and bends of elbows, both groins, flexures of knees, the surface of the back to some extent, and the genitalia is deeply pigmented and thickened.

The skin has an oily, velvety or spongy feeling; the natural lines and folds are greatly exaggerated, some of them being very deeply fissured. These fissures do not crack irregularly into polygonal or other plate-like formations. There are no raw or excoriated places, even at the bottom of these fissures—in fact there are no unusual or irregular lines or fissures, the natural lines of the skin being preserved, but their depth is very much exaggerated.

The appearance of the skin at the present time is very well shown in the cuts which illustrated the former article, and the photograph accompanying this article. I would suggest that in studying the photograph, a reading glass be used, when the characteristic lines and fissures are beautifully shown. The photo also shows the small papillomatous growths on the face, which are so characteristic of this disease.

A portion of one of the hypertrophied ridges in the axillæ was excised by me, a section prepared by Dr. T. R. Griffith, and a micro-

photograph made. The photograph, as will be observed, is typical of a papillary skin hypertrophy. There is no scaling of the superficial layers as is shown in ichthyosis. The pigmentation is also clearly shown in the photograph.

The condition is manifestly an hypertrophy of the papillary layers of the skin, in which is preserved the natural lines. There are numerous small, deeply-pigmented papillomatous growths, none more than 5 mm. in diameter, scattered over the affected area, especially upon the face.

The surface is not dry and scaly, as it was reported to be in the former paper. There is no growth of hair upon the affected areas. The other organs of the body are normal in appearance and function.

In my opinion, this is clearly a case of Acanthosis Nigricans. In ichthyosis, the skin is rough, dry and thickened. It cracks and forms numerous polygonal plates, and tends to peel at the margins. Pigmentation is not usually so marked as in this case. The natural skin lines are not followed uniformly. There is not the smooth, papillary hypertrophy, and oily, velvety feeling that is to be found in this case. The skin becomes dry and parchmentlike, and the disease occurs upon the extensor surfaces. On the other hand, acanthosis nigricans is charaterized by pigmentation and thickening of the affected areas, in which the natural lines are preserved.

It is accompanied by numerous papillomatous growths; it is distributed over the neck, groins, axillæ and flexures generally, back of the hands, upon the face and orifices of the body (where the mucous membrane is usually affected), as well as upon the trunk. The axillæ are most markedly involved. In these cases where the skin shows many thickened tranverse folds, the palms of the hands, soles of the feet, and the nails are usually affected. Two-thirds of the cases occur in persons beyond middle life. Quite a large proportion of the cases are associated with cancer. This is a rare disease—only about thirty cases having been reported up to 1905.

The above clinical picture is modified in many cases.

Crocker of London reports a case in a young and vigorous man of twenty-two, in which the pigmentation and soft papillomatous growths were highly developed, but the hands and mucous membranes were free.

In the first case reported by him, the disease developed at the age of fourteen. In all cases occurring among young people, the general health has been good, and cancer has not been a factor.

I take exception to the conclusions in the former report of this case in the July, 1907, number of this journal as follows:

First. The plate-like scaling is not present, and he gets along very well with the usual number of baths taken by any cleanly individual.

Second. While the mucous membranes are not involved in this case, neither were they in the case reported by Crocker and some others.

Third. Carcinomatous growths, so far as I have been able to gather from case reports, do not occur in the younger individuals.

Fourth. As to increased pigmentation along the line of the veins in the affected area, in this case, the skin is hypertrophied to such an extent that the veins are not visible.

Fifth. In the authorities that I have been able to consult, I do not find that blood changes are present. Possibly there are some reports that are not at my disposal, which may render this point of more import.

Sixth. As to the improvement during the summer months, we have perpetual summer in Southern California; the young man has shown some slight improvement in the past six months, and has had no eczematous complications. This improvement may be due to the fact that he has been taking thyroid extract for about four months.

Seventh. The general health of *young* patients suffering from acanthosis nigricans is usually good.

Eighth. As to the palmer and plantar keratosis not being present, this was also true in Crocker's case reported above.

Ninth. As to involvement of hair and nails, this may or may not occur in both diseases.

Tenth. As to the contention that the long duration of this case should have caused more characteristic symptoms of acanthosis, I can reply with more than equal emphasis that the long duration of this case should have caused *some* characteristic symptoms of ichthyosis.

The case is a very unusual one. I feel that his attending physician had good grounds for the diagnosis suggested in the first report, *but*, in view of our further observation of the case, and with another year's history before us, I feel that acanthosis nigricans is undoubtedly the proper diagnosis at this time.

PLATE XXVI.—To illustrate Dr. W. W. Roblee's Article.

ACNE AGMINATA.

(A CASE OF)

By William B. Trimble.

Instructor in Diseases of the Skin, New York University (University and Bellevue), Chief of the College Clinic and Assistant at the New York Skin and Cancer Hospital.

THE rarity of this affection is adequate reason for its report, and it is thought the record may be of interest to the profession.

During the spring of 1907 the patient presented herself for examination and treatment at the New York Skin and Cancer Hospital in the out-patient service of Professor Fox, with whose permission I report the case. She was assigned to my care, and the following notes were taken:

M. Y., Woman; age forty-two; married; nativity, Russian; strong, healthy looking; dark type; nervous temperament; weight about 160 pounds.

Family History—Father and mother dead; both lived to good old age, beyond 70. Patient has had two brothers and one sister, all of whom are dead. One brother was killed in a railroad accident; the cause of the other's death is unknown. The sister died of tuberculosis. There is no history of any skin disease in the family.

Personal History—She has no children and has had no miscarriages. If her memory is correct, she was afflicted with most of the diseases of childhood, including measles and scarlet fever. Since that time she has enjoyed good health, until the winter of 1906, when she was seized with a severe attack of la grippe; this was followed by rheumatism, which confined her to bed for a period of six weeks or more. The skin disease made its appearance during the latter part of this illness.

Present Conditions—The disease is confined to the face, mainly on the cheeks and eyelids, both upper and lower, and the upper lip. These locations are covered with a papular efflorescence, the individual lesions of which are discrete, varying in size from a pin head to a millet seed.

The incipient papule can be felt sometimes before it is visible. The color varies with the stage of development of the lesion; during evolution they are dusky red with a mild inflammatory areola, the centre then becomes yellow, and finally suppuration ensues; while the papule is in the stage of retrogression, it takes on a yellowish brown hue and a pigmented scar is left, the pigmentation lasting for some time.

Some of the earlier lesions have a distinct waxy appearance, and although seemingly solid, pus was extruded, when they were punctured.

The disease is well developed for so short a duration, which is only three months at this writing. The patient refused to have a biopsy made, but the clinical diagnosis is quite clear; she may submit to this later.

The urine examination was negative.

No attempt will be made to classify this disease; some authors describe it separately from folliclis, while others claim they are identical. It does not seem improbable that it belongs to that group of affections called tuberculides, using that term strictly in a generic sense.

PLATE XXVII.—To illustrate Dr. W. B. Trimble's Article.

SOCIETY TRANSACTIONS.

THE NEW YORK DERMATOLOGICAL SOCIETY.

356th Regular Meeting, March 24, 1908.

Dr. E. B. Bronson, President.

Papulo-necrotic Tuberculide of Extensive Distribution. Presented by Dr. J. A. Fordyce.

The patient was of German birth, twenty-two years old, by profession a musician. His father died when thirty-eight of tuberculosis; his mother died in middle life; cause of death unknown. He denied any venereal infection.

In November, 1907, he first noticed an eruption on the extensor surfaces of the forearms, which was pustular in character, rather superficially situated and extended to the upper arms, the trunk and the face. These pustules in the course of three or four weeks healed with the production of very sharply defined superficial scars. The punched-out appearance of the scars was especially noticeable about the face.

About the time the eruption appeared on the forearms he had a sore throat and he entered one of the hospitals of this city, where he was treated for about two months with injections of insoluble mercurial salts. During the administration of mercury, new crops of lesions appeared. He left the hospital in question and entered the City Hospital, where he came under the observation of the writer. He then had numerous depressed scars over the face and body. They were especially numerous over the shoulders and upper half of the back, where they were pigmented and grouped very much after the manner of a luetic eruption. Many of the scars about the shoulders presented a slight keloidal thickening. There were a few scattered lesions over the anterior portions of the trunk and over the thighs and legs. His palms and soles were free. In addition he presented a group of suppurating lymph nodes at the angle of the jaw. These were subsequently opened and drained.

On account of the absence of history or any evidence of a primary syphilitic lesion about the genitals or the throat, the suspicion was excited that the eruption was a tuberculide and not a syphilide. This was strengthened by the suppuration of the lymph nodes and the positive reaction of the ophthalmic tuberculin test. He presented also a scar in the left inguinal region which he states resulted from a suppurating lymph node some years ago. At that time he had no genital lesion.

DISCUSSION.

Dr. Fox would not say that the man did not have syphilis, but he had never seen a papular syphilide leave so many small punched-out ulcerations except in connection with tuberculosis.

Dr. Jackson said that it was an extraordinary syphilitic lesion in its being located so markedly on the back, and in the depth of its scars. He was inclined to agree with Dr. Fox that it was a syphilide modified by occurring in strumous subject.

Dr. Morrow said that he saw nothing in the appearance of the case inconsistent with the diagnosis of syphilis. The lesions on the shoulder which formed the most conspicuous feature were such as are ocassionally seen in syphilis. The glandular complications, and the suppurative tendency were somewhat unusual, of course, but on the whole he was inclined to believe the case to be one of syphilis rather than tuberculide. The history of marked enlargement of the glands which has since disappeared, would support the diagnosis of syphilis.

Dr. Klotz stated that this patient had been under his observation in the German Hospital. When first seen early in December the larger part of the body was covered with lesions of different character. There were flat, isolated, red papules of decidedly syphilitic character and slightly infiltrated, scaly patches besides the pustules which principally covered the upper part of the back, the shoulder and the face and left the deep pitted scars. Under antisyphilitic treatment (injections of the salicylate of mercury) the former lesions promptly disappeared, but the pustular ones continued to appear in new crops; they began as a small red papule bearing a minute pustule in the center under which later circumscribed necrosis was developed with cicatrization; the picture was that of what we used to call acne varioliformis. Under local treatment with the white precipitate of mercury the eruption of new lesions finally stopped. In January the patient became affected with an inflammation of the throat without any specific character, rather a subacute tonsillitis, accompanied by considerable fever and swelling of the glands of the neck, with no tendency to suppurate. A moderate fever continued even after the tonsilitis had subsided and a complication of syphilis with tuberculosis was suspected. The patient left the hospital in fair condition, ostensibly to resume his former position on a steamship.

Dr. Whitehouse agreed with Dr. Fox that he had never seen a pustular syphilide produce such scars as this man showed, but from Dr. Klotz' study of the case it was evident that the man had syphilis—that, however, was not the whole thing in his opinion, as the tuberculin test for the eye has given a positive reaction for tuberculosis, although this could not be depended upon as absolute. He was inclined to believe it to be a mixed case, syphilis in a tubercular subject.

Dr. Elliot said that from the appearance of the scars left by the lesion and the character of the primary lesion, as seen on the face, he would unquestionably consider the case as one of so-called tuberculide. In view of the fact that Dr. Klotz had had the patient under treatment for syphilis and the lesions had nevertheless continued to recur, strengthened in his opinion the diagnosis.

Dr. Fordyce said he was very glad to hear Dr. Klotz' statement that the throat trouble which the patient had when under observation in the German Hospital was not syphilis, as this seemed to throw some light on the primary infection. It seemed to him that the tuberculous focus was in the throat, leading to subsequent suppuration of the lymph nodes, and it was possible that the skin eruption could be referred to this infection. It was generally recognized that this form of necrotic tuberculide could not easily be differentiated from syphilis. While it was possible that the patient might have had syphilis, as Dr. Klotz stated, it seemed to him that the eruption might be explained on the other hypothesis. The patient undoubtedly had tuberculosis and whether he had

syphilis in addition was a question which subsequent observation would confirm or deny.

Case for Diagnosis. Presented by Dr. Fox.

The patient was a Roumanian, who came to this country three months ago, and had lesions of a serpiginous character over the abdomen and inner aspect of the thighs.

DISCUSSION.

Drs. Dade, Robinson, Fordyce, Mewborn, Elliot, and Jackson agreed that it was a parasitic condition, probably trichophytosis, but several of them expressed a desire to know the result of a microscopic examination, before a definite diagnosis could be made.

Dr. Morrow said that he had often seen a condition similar to that on the abdomen, in tropical climates, but that he had never seen the peculiar and characteristic lesions on the buttocks and back. It was his impression that it was a case of tropical tinea.

Dr. Johnston said that he saw no evidence at present to support the eczema marginatum. What particularly impressed him was that the disease instead of developing between the scrotum and thighs (the site of predilection in eczema marginatum) commenced lower down on the inside of the thighs and extended upward. The elevated or verrucous border was also peculiar. Moreover, the disease was too deep seated apparently for a parasitic affection.

Dr. Fox said that the case had excited a great deal of interest among his assistants at the Skin and Cancer Hospital. The thickening of the skin and the intense pruritus, of which the patient complained, did not comport with an ordinary case of trichophytosis, but from the serpiginous character of the patches he was inclined to think the parasitic view a correct one. A section had been made, but the report had not yet been received. It had not occurred to him that it might be parasitic but the peculiar outline of the patches beneath the scrotum and upon the thighs, leaving the skin perfectly healthy about them, was so different from eczema marginatum that that diagnosis did not seem probable.

Dr. Elliot said that the infection did not necessarily have to take place in the crotch, it might occur anywheres. He considered the case to be one of tinea.

Dr. Bronson said that an infection so general as this would affect the parts which were most susceptible, and no part is so susceptible as that between the scrotum and the thigh.

Dr. Fox said that it seemed strange that it should extend in a sort of band in a region where there was so much heat and irritation, without producing a diffuse inflammation.

Case for Diagnosis (Child of about five years, with peculiar eruption on the backs of the legs). Presented by Dr. Dade.

The lesion first appeared eighteen months ago. There is no specific history. The mother has several other children all healthy. This child is in fine physical shape, and has had no drugs except castoria. The condition started on the legs and the child is constantly scratching the va-

rious spots. At present the appearance would warrant a diagnosis of bromide eruption so closely does it resemble the spongy, pus-soaked, hypertrophied lesions not infrequently seen in children given bromides. This can be ruled out though on close questioning of the mother.

DISCUSSION.

Dr. ROBINSON said that he had thought at first that it was an infection; in some places now it seems as if it might have been produced by some drug.

Dr. MEWBORN said that he was inclined to agree with Dr. ROBINSON that some drug had caused the eruption.

Dr. FORDYCE was still firmly convinced that the case was one of erythema induratum, with secondary pyogenic infection. He was not familiar with any other form of infection that would produce lesions of this character.

Dr. ELLIOT said that had not bromide been emphatically excluded he would have thought it a bromide eruption, and he certainly could see no indication of Bazin's disease in the case.

Dr. JACKSON thought it was not a case of Bazin's disease, but an infective process, a verrucous dermatitis, similar to that case he had exhibited, which was located on the leg of a man and had lasted for many months. He thought that the use of a stronger ointment of salicylic acid would still more improve the case, and he would see that it was used on one leg.

Dr. JOHNSTON said that he saw no evidence at present to support the diagnosis of Bazin's disease. There are, however, modifications of every clinical concept, and Bazin's disease may offer no exception to the rule. He thought it might better be described, on account of this verrucous surface, as a fungating dermatitis (dermatitis vegetans).

Upon being asked to define a fungating dermatitis, he said that it was simply an hyperplasia of all the skin structures of almost any origin, bacterial, medicamentous or metabolic inflammation. Several of the members of the American Dermatological Association had reported somewhat similar cases.

Dr. WHITEHOUSE said that the lesions did not appear to him to be those of erythema induratum. They were too superficial, they were not ulcerating, and not deep seated as in Bazin's disease. He adhered to his original diagnosis of infectious dermatitis. The results of the treatment to which it had been subjected would seem to bear out that diagnosis.

Dr. SHERWELL had not changed his opinion since seeing it last month, believed it to be an auto-infection of staphyloccocic nature in a child of depraved diathesis, calling it strumous or scrofulous as one will.

Dr. DADE said that in support of Dr. Fordyce's diagnosis, he would call attention to the fact that since last presented there had formed a large indurated plaque at the upper part of the right leg; this plaque was 2 by 1 inches in size, had softened and broken down, discharging its contents of thin bloody pus. Since the child was here last the legs have been kept in dressings constantly, and it has not been able to scratch at all. The lesions have been treated constantly with aluminium acetate or creolin. Had it been a case of simple infection it should have gotten well in a month. The condition has now lasted for two years. It is improved but by no means well.

Pityriasis Rosea. Presented by Dr. DADE.

The patient was a little girl about five years of age. The lower part of abdomen shows a diffuse eruption, but some scattered outlying lesions are sufficiently characteristic to make the diagnosis, one in particular showing well the chamois-colored crinkled center.

Dr. DADE said that when the child came to the clinic this afternoon the parents showed some dark colored salve which they had been using. He could not identify it. The body was covered with it, and the lower part of the abdomen from its use was almost weeping. He sent the child home to have a bath, and the condition presented now is very different.

Case for Diagnosis. (Prev. shown.) By Dr. E. B. BRONSON.

Dr. BRONSON said that he first presented this case some months ago with the tentative diagnosis of lupus erythematosus with telangiectatic character. The vascular element was very marked, and there was not much desquamation. When presented before, the lobes of the ears showed dark, purplish nodules the size of split peas, which had since been reduced by application of the unipolar high frequency spark. The same treatment had been used with some success on some of the patches on the face. Aside from this the treatment had consisted of occasional applications of strong (50 p. c.) resorcin-gelanthus and at night 15 per cent. tumenal-sulphuric-acid-gelanthus.

DISCUSSION.

Drs. JOHNSON, WHITEHOUSE, MORROW, SHERWELL, DADE, agreed with the diagnosis of lupus erythematosus.

Dr. FORDYCE agreed with the diagnosis of lupus erythematosus, but thought it was a very uncommon type. Lupus erythematosus is usually a progressive disease, but here it seemed to have entirely disappeared and left a pigmentation behind it. In studying the etiology of lupus erythematosus, he had lately employed the ophthalmo-tuberculin test in this affection, but he had obtained no reaction in any of them.

In response to inquiries Dr. BRONSON said that the condition had existed for four years. Microscopic examination showed the changes to be chiefly about the blood vessels, with new formations, besides thickening of connective tissue. There was found no evidence of tuberculosis in the tissue examined.

Case for Diagnosis. Presented by Dr. Fox

The patient was a stout well-nourished girl of about thirteen years of age. A year ago she was perfectly well. Last fall she had an eruption on the face, leaving a pigmentation and pigmented spots are now scattered over the body. Rubbing of the skin produces no elevation. The lesion on the face seems to be secondary.

DISCUSSION.

Dr. WHITEHOUSE thought that although the case had been going on for so long there was definite evidence of scabies and this would perfectly well account for the dermographism and urticaria, both of which are not unusual in cases of scabies.

Dr. ELLIOT thought that there was some other condition present than scabies, and from the condition of the skin as a whole he was inclined to call it prurigo.

Dr. SHERWELL thought that in the discussion the, to him, main feature of the case had not been sufficiently dwelt on—he referred to the lividity of skin

on arms, dorsa manus, and other parts, he looked upon the trouble as having some characteristics of a neurotic erythema, a form of urticaria.

Dr. Fox said that the diagnosis of scabies was considered among others at the hospital. By daylight her body appears covered with atrophic and pigmented spots which are certainly not the result of scabies. At the first glance she appeared to have urticaria pigmentosa, but brisk rubbing failed to produce the elevation of urticarial lesions. She may have scabies, but that cannot account for the peculiar eruption over the body.

Case of Alopecia Syphilitica. Presented by Dr. Fox.

Dr. Fox said that he had shown this patient, not on account of its rarity, but because the question of syphilitic alopecia had been recently discussed. He claimed that in early syphilis we are very apt to see alopecia in the form of a general defluvium, or as plucked-out, partially bald spots, which occurred on the site of macules or papules of the scalp whether these had been noticed or not. In this case the eruption was mostly on one side, but there were two or three bald spots, having the plucked-out appearance so often seen on a man's occiput.

As for the alopecia of late syphilis, he claimed that although alopecia areata had been described as occurring in certain syphilitic subjects it is not necessarily a symptom of syphilis. Syphilis may be one of many causes, but the round partially bald spots which occur, without preceding ulceration, years after a syphilitic infection, should not be always regarded as late syphilitic alopecia.

A Case of Prurigo. Presented by Dr. J. A. Fordyce.

The patient was a boy, eight years old, of Russian parentage, but born in this country. He gave a history of pruritic eruption during the past four years. The eruption was a typical one of rather marked prurigo involving the extremities and face. The child had been refused admission to the public schools on account of the belief of the examiner that the case was one of scabies. The lesions were very numerous on the backs of the hands and about the fingers and such a diagnosis, on account of the pruritic symptoms, could easily be made by one who was not an expert in these affections.

A Case of Miliary Papular Syphilide Resulting in Large Circinate Patches. Presented by Dr. J A. Fordyce.

The patient was twenty-five years old. In October, 1907, he had an initial lesion followed by lesions in the mouth and by a characteristic alopecia; then by a disseminated erythematous rash. The present eruption involved the face, trunk and extremities, and was especially marked over the upper half of the back and shoulders. It was present in large coin-sized circinate lesions which were dark brown in color, and made up of small miliary papules. The latter were especially noticeable when the skin over the lesions was made tense.

Case Suggesting Von Recklinghausen's Disease. Presented by Dr. Dade.

A case of Von Recklinghausen's disease, showing a very marked amount of pigmentation in large plaques and a great number of subcutaneous and cutaneous humors—one large one on right shoulder. Over the abdomen the tumours were most numerous and around the neck over the chest and shoulders the characterisic prickling was most marked, with very large plaques of pigmentation over left flank and right side of back low down.

For Diagnosis (Psoriasis or Syphilis?) Presented by Dr. Mewborn.

A. C., aged fifty-nine years, was born in Brooklyn. Her father was a mulatto with teutonic blood for the white strain. Her mother was mulatto with mixed Indian and negro blood.

She had a child by a white man. Child died at two and a half years of age. Shortly after she married a negro. She had three or four miscarriages. About this time, twenty-five years ago, she had repeated operations for fistula in ano, leaving behind some stricture of the rectum. She lost the first husband and married again to a negro. No children.

Outside of the rectal trouble she has had no illnesses to speak of until last November she noticed that her hair became thinner and there was a considerable formation of scale in the scalp. About the same time an inflammation started at the matrices of several nails, some pus could be expressed, and a perionychia developed with deformity of the nails. Nails became thick, friable, yellow. Toe-nails also became affected. She had some chilly sensations and a rash came out on the body. Patches on the elbows, knees, arms, legs and back.

The lesions on arms are very much like psoriasis, only most of the scales have been removed. The scales present are somewhat mica-like, and are easily removed, showing the pellicle described by Brocq, and with further scratching the punctate hæmorrhages. On the legs some of the scales seem to have some pus formation. The nails look somewhat like psoriasis of nails, only the perionychia causes a suspicion of lues.

The lesions in the scalp are typical of psoriasis of the scalp.

DISCUSSION.

Dr. Fordyce said that psoriasis would explain most of the lesions, though there might be a secondary pyogenic infection about the nails of the toes.

Dr. Robinson considered the case to be syphilis and not psoriasis, from the objective character of the lesions; and the condition of the nails confirms this diagnosis.

Dr. Sherwell believed it to be a symbiotic affection with most pronounced syphilitic character.

Drs. Morrow, Klotz, Johnston, Jackson, Elliot, thought it a case of syphilis.

Dr. Whitehouse said that it was a most interesting case. The patient had come to the Skin and Cancer Hospital the day before, but he had not time to get the history. Two clinical features, however, seemed to be most pronounced —the condition of the nails and the psoriatic character of the lesions themselves, and besides there was a great deal of itching. He was at first inclined to the diagnosis of psoriasis, but thought the question of syphilis should receive careful consideration. The nails, the itching, and the character of thes patches themselves sustained the former view. The dry scales on some of the lesions were very well marked on both knees.

Dr. Fox said that at first glance he felt certain that the eruption was syphilis, but later was inclined to the diagnosis of psoriasis. He hoped that by further study Dr. Mewborn would be able to decide positively between the two, and that he would again present the case.

Granted that it was a case of psoriasis, the woman was no more a negro than a Caucasian. Indeed she is more of a Caucasian than a negro. While psoriasis may occur in mulattoes he has never personally known of its occurring in a black negro.

Dr. Bronson said that one feature in regard to the nails struck him as important in indicating syphilis. He had never seen psoriasis cause disease of the matrix with a disturbance in the growth of the nail, and the free border of the nails intact, as in this case. The decided process in the matrix accompanied with infiltration does not comport with anything that he has seen in psoriasis.

Dr. Mewborn replied that there were differences in the nails. In some, mostly in the terminal part of the nail where it was yellow, friable; but on one of the thumbs, it seemed to start in the matrix. The woman has patches on the scalp which are covered with the characteristic shiny, mica-like scale of psoriasis. He thought the great pigmentation was partly due to the natural color of the skin.

He did not exclude syphilis, as the woman has a history of multiple miscarriages, and a history of stricture of the rectum.

Case of Mycosis Fungoides. Presented by Dr. Fox.

The patient, an elderly woman, has had this disease for seven years, but it has been much worse this last year. It has disappeared in some places and appeared in others. She shows the characteristic semicircular and bull's-eye patches, *i. e.*, a papule with a raised circle around it.

The diagnosis was generally sustained.

Initial Lesion of the Anterior Nares. Presented by Dr. J. A. Fordyce.

The patient, a man about twenty-five years old, presented an ulceration involving the anterior nares on the right side and leading to a considerable amount of infiltration and induration of the ala nasi. The ulceration was accompanied by enlargement of the group of lymph nodes at the angle of the jaw, more noticeable on the side opposite to the lesion. The patient also presented a beginning roseola. He did not have any genital lesion.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON DERMATOLOGY.

Stated Meeting Held February 4, 1908.

Dr. A. R. Robinson in the Chair.

Paget's Disease. Presented by Dr. Lapowski.

The patient is 46 years old, married. She has been pregnant seven times and had seven living children, of whom the fourth and seventh died at 6 and 9 years of age, respectively. The cause of death could not be established. The patient is not aware of any syphilitic disease. Four months ago a dollar-sized itching red patch appeared on the left breast, and two months later the patch ulcerated; in the meantime two other lesions appeared. She came to the Good Samaritan Dispensary several days ago in the same condition that she presents this evening. On the upper surface of the left breast, two inches to the right of the nipple, is a well-defined superficial ulceration the size of a quarter-dollar, with a reddish, slightly infiltrated border, giving a feeling of slight hardness when taken between the fingers. The surface is even, not raised above the level of the skin, only slightly bleeding, and covered with red, clean granulations. Three and a half inches to the left of the nipple are two separate pea-sized, deep ulcerations, funnel-shaped, but with sharply cut borders, deep and dry floor, having the aspect of gummata. The surrounding skin is only partially red, and only very slightly infiltrated. All the sores are painless. There are no enlarged glands in the axilla. The veins are very markedly developed on the affected breast above the ulcerations, reaching up to the clavicle.

Dr. Gottheil said that he believed one lesion to be Paget's disease and the other syphilis.

Dr. Howard Fox said that he believed that both of the lesions were syphilitic.

Dr. Dana Hubbard believed one lesion to be Paget's disease and the other syphilis.

Dr. Trimble called attention to the fact that Paget's disease, when on the breast, is most apt to be upon the nipple itself, while in this case it had not that location. Although one of the lesions clinically somewhat resembled Paget's, the other, with its deep-seated ulceration, and punched-out appearance, was quite characteristic of lues, and his opinion was that the whole process was one of that disease.

Dr. Robinson agreed that one lesion, on account of the non-elevated epithelial margin and firm, red base, may be Paget's, although it lacked the usual appearance of the base in Paget's disease, and also was not connected with the nipple; the other lesion was, he believed, syphilitic.

Dr. Pollitzer called attention to the fact that Paget's disease in the beginning is a special form of eczema, while the lesions in this case are described simply as ulcers; why then call it Paget's disease?

Dr. Lapowski, closing the discussion, said that if the lesion which nearly all

agreed was Paget's disease came first, as it did, then a lesion of tertiary syphilis appearing later should appear at the same site, as being the place of least resistance.

Acne Varioliformis. Presented by Dr. HOWARD FOX.

The patient is 30 years old, single, Irish-American, locomotive engineer. He contracted syphilis thirteen years ago. Four years ago the present eruption began. The lesions have been constantly appearing since then and he has never been entirely free of them. They appear on the scalp and forehead near the hair line as "pimples," which in many cases break down and form crusts. Some of these lesions are followed by pitted scars. They require about six weeks to two months to complete their evolution. There is only moderate itching. White precipitate ointment has often benefited, but never cured him. A recent strict diet is accountable, according to the patient's opinion, for a decided improvement in the eruption.

Active Bromide Eruption. Presented by Dr. LAPOWSKI.

The patient is a child of four years who has been taking an "anti-epileptic mixture." She now shows a bromide acne on the face, and hypertrophied bromide patches on the left thigh.

Healed Bromide Eruption. Presented by Dr. LAPOWSKI.

The patient is a girl of sixteen, who has suffered for the past seven years from attacks of nervous coughing and who has been treated with bromides. She came to the Good Samaritan Dispensary with hypertrophied patches of bromide eruption on the sites of the present dark brownish spots on the two thighs. The bromides were stopped entirely and she was given twelve injections of atoxyl, each being 0.5 c. c. of a 15% preparation, and locally mild antiseptic lotions. The active lesions have now all disappeared.

DR. DEVLIN said that he had seen a typical bromide eruption in an adult, as a result of taking 10 ounces of a solution of stronium bromide containing about 20 grammes of the salt, in one week, although this salt is said never to produce an eruption.

DR. LAPOWSKI, closing the discussion, said that after using mild antiseptics externally and atoxyl internally, he had observed great improvement, both in the epilepsy and in the local condition.

Naevus Pilosus Treated with Carbon Dioxide Snow. Presented by Dr. DANA HUBBARD.

The patient, a little girl, shows the progress of the treatment. Where the freezings have been done the pigmentation and the heavy coarse hair have disappeared. The patient is about four-fifths cured; treatment is being continued, and the patient will be shown again later.

For Diagnosis. Presented by Dr. TRIMBLE.

The patient is a man of twenty-six, from the service of Dr. Fox at the New York Skin and Cancer Hospital. Both ears have been affected for the past eight years. As a rule, the lesions do not appear as deep-seated papules, as is the case with many tuberculides, but occur as small tumefactions, which after a varied length of time break down, discharging a rather thick pus. This is followed by scarring. The process has continued slowly until the whole helix and lobule are affected, and the disease is encroaching slightly on the face. There is no history of venereal or of tuberculous disease.

Pathological Report. The epidermis over the most intense part of the infiltration is thinned in places. The follicles are somewhat dilated and partially filled with parakeratotic horny material. Emigrated leucocytes are present in the epidermis. The main focus of infiltration is situated in the upper third of the corium, and consists of lymphocytes and plasma cells and proliferated fibroblasts. The distribution seems to be about the hair follicles. Isolated foci of infiltration in the deeper parts of the corium show a perivascular disposition. Some vessels are dilated and others have the lumen obliterated in the dense infiltration. The subepidermic portion of the corium is somewhat œdematous, and here and there is a very mild suggestion of degeneration of collagenous tissue.

DR. LAPOWSKI said he believed lupus erythematous could be excluded on account of the deep scars.

DR. HOWARD FOX said that he believed this to be a case of lupus vulgaris and not lupus erythematosus on account of the history of sores, thick crusts and healing with scars.

DR. GOTTHEIL said that he believed it to be a case of tuberculosis of the skin, not tuberculide.

DR. DANA HUBBARD said that he believed it to be a case of tuberculosis of the skin, on account of the great destruction of the tissues.

DR. TRIMBLE, closing the discussion, said that this case presented no apple jelly nodules and no giant cells or other pathological evidence of lupus vulgaris. He thought probably the case might be considered as one of the aberrant forms of lupus erythematosus, as the pathology pointed slightly that way; his own diagnosis, which was provisional, was lupus pernio.

Psoriasis in a Negress. Presented by Dr. DANA HUBBARD.

The patient is a girl six years of age. Her father, who comes with her, is of pure negro type. She appeared this afternoon at Professor Jackson's clinic. For the past four years patches of various size and shape have appeared on different parts of the body, each lasting about a month, and then disappearing. The disease is said to have been followed by an attack of black "measles." There is slight itching; no scratch marks are in evidence to-day. The eruption is general, involving scalp, ears, back of thighs, anterior surface of forearms, knees and trunk.

The scales are superficial and easily scraped off, showing bleeding points on the surface beneath. The patches appear to clear up in the center first. The patches on the forearms look like eczema, but in view of the history and appearance of the lesions elsewhere, psoriasis seems the more probable diagnosis, in spite of its rarity in the colored race.

Dr. Howard Fox said that in his opinion the case was not one of psoriasis, as that disease is extremely rare in the pure blooded negro. On this patient, also, the eruption had not the ordinary distribution of psoriasis.

Dr. Gottheil said that he had never seen a case of psoriasis in a negro without well marked scaling, showing with especial distinctness on the dark skin. He regarded the case as one of chronic eczema with lichenification.

Dr. Dillingham said that he considered this case one of lichen planus. In a case of psoriasis which he had seen that day in a half-breed negro, there was not much scaling.

Dr. Lapowski said that he believed the case to be one of lichen planus, basing his diagnosis on the appearance of the skin lesions, and especially upon the white patches in the mouth. He did not believe that chronic eczema with lichenification would occur in such wide distribution and without very visible signs of scratching.

Dr. Pollitzer said the lesions in the mouth were of an acute inflammatory nature, and not lichen planus.

Dr. Dana Hubbard, closing the discussion, said that not much stress could be laid on the location of the lesions in making a diagnosis of psoriasis, on account of the frequency with which the so-called sites of election are left unaffected. He had seen one other case of psoriasis in a negro. In this patient, the lesions come and go, without much itching. He was willing to accept the diagnosis of lichen planus, as being at least as probable as psoriasis.

Lupus Vulgaris on the Abdomen. Presented by Dr. Lapowski.

The patient is a woman thirty-five years of age, married for fifteen years. There is neither family nor personal history of tuberculosis. On the abdomen below the xiphoid process is a penny-sized round patch with ulcerated tubercles at the border. On the floor of the ulcer are seven pinhead-sized tubercules, undergoing necrosis; the intervening space of the floor is granular and red. The patch is slightly hard to the touch.

Dr. Pollitzer agreed with the diagnosis, and advised extirpation by the knife with direct union or possibly skin grafting as the simplest, most expeditious, and most radical method.

Dr. Dana Hubbard said that in such a case he considered extirpation the best treatment; and if that were refused, then the X-ray, with freezing by liquid air or by carbon dioxide snow as third choice.

Pityriasis Rosea Occurring in a Syphilitic. Presented by Dr. Howard Fox.

The same patient was shown here December 3, 1907, with dermatrophia linearis. He is eighteen years old, single; a collector, born in the United States. Six months ago he was treated at the Skin and Cancer Hospital for a hard chancre, followed later by a perfectly typical

roseola and general adenopathy. As soon as the diagnosis was established he was put upon internal antisyphilitic treatment, which he has continued to take faithfully up to the present time. About two weeks ago an eruption appeared upon the trunk and arms of pinkish macules, the majority oval in shape, and varying in size from a bean to a five-cent piece. One patch is as large as a quarter of a dollar. There is slight infiltration and scaling. None of the lesions show typical buckskin centers. Some of them show a fairly well-marked border. The patient shows a marked example of the "moth-eaten" form of syphilitic alopecia.

Dr. Gottheil said that although some few of the lesions present might be syphilitic, most of them were typically those of pityriasis rosea.

Dr. Lapowski called attention to the varying character of the different lesions, some showing scaling only, and some showing slight and others more infiltration. Those with a slightly raised border, a depressed center, and slight scaling, he thought were merely syphilis. The simple scaling might be caused by ointments. Treatment would make the diagnosis by causing the disappearance of the lesions in three weeks.

Dr. Williams said that the disappearance of the lesions under antisyphilitic treatment would prove nothing, because lesions of pityriasis rosea would probably disappear in three weeks, whether treated or not.

Dr. Pollitzer believed the lesions were surely those of pityriasis rosea.

Dr. Robinson believed all the lesions were syphilitic, possibly modified in appearance by infections by the organism of eczema seborrhoicum. Syphilis is such an imitator of other diseases that further observation of the case is necessary for a positive diagnosis.

Tubercular Leprosy. Presented by Dr. Howard Fox.

The patient is twenty-three years old, single; a ship steward, of English parentage. The family history negative. He was born in the Port of Spain, Trinidad, where he lived until he was twelve years old. He then moved to New Haven, Conn., remaining three years, and then moved to Brooklyn. A few months later spots upon his trunk appeared and his face began to swell. Several years later sores began to appear on his feet. Three or four years ago his voice began to be hoarse, and he noticed sores in his mouth. Sores on hands appeared within the past year, following a ten months' trial of a patent medicine. Examination shows typical facies of tubercular leprosy. Over the trunk and extremities are large and ill-defined red macules, which for the most part show no change in sensation. The ulnar nerves are enlarged. There are superficial ulcerations about some of the fingers and toes, and on the insteps. The nails are all involved, broken off piecemeal, and show blackened crusted masses. The eyes are unaffected. There is atrophic rhinitis, catarrhal otitis media, and extensive superficial and deep ulceration of tongue, fauces, tonsils, pharynx, and larynx. The urine shows bacilli, stained with Ziehl's solution, which are similar in appearance to tubercle bacilli and which are all extra cellular.

Tuberculide. Presented by Dr. Lapowski.

The patient is thirty years old, married three years ago. Five years ago he came to the Good Samaritan Dispensary, and the following notes were taken: Patient slight. On the posterior surface of the left thigh, below the buttock, there is a longitudinal lesion, with red, slightly bleeding granulating indolent floor, covered with thin yellowish pus. The lesion looked like an ecthyma. There was neither hardness nor any glands perceptible. On the whole trunk, from neck down to the middle of the thighs, there was visible a macular eruption, especially pronounced on the lumbar regions, the lower part of the abdomen and the sacral regions. The macules were round, pea-sized, with normal skin intervening, giving a net-like aspect to the surface, the openings of the net being the macules, the normal skin the connecting links. On the sides of the abdomen, just above the pelvis, on the anterior and posterior surfaces of the thighs, and on the buttocks were papules of various aspects; some millet-sized, with a flat reddish surface, slightly raised above the level, lying in the macule, the dark-brownish borders of the macule surrounding the papule; others, especially on the thigh, had dry, dark bloody crusts in the center, the removal of which left a necrotic wet center, with sharply defined edges, reaching deeper into the skin. In some parts dark, round, pea-sized pigmentations and minute to large pinhead-sized scars were seen. The eruption did not itch, and, according to the patient's statement, it was at this time of two months' duration. No glands were perceptible. The visible mucous membranes were free. I diagnosed "follicli s" and prescribed baths and antiseptic treatment for the ulcerations. But on subsequent visits I changed the diagnosis to syphilis, owing to the striking appearance of the macular eruption and to the presence of flat papules—considering the necrotic papules as local autoinfections. Rubbings were administered. The patient then disappeared from the Good Samaritan Dispensary. In October, 1907, about three months ago, he returned to the dispensary with a longitudinal ulceration in the right fossa cubitalis—and, to my surprise, with the same lesions on his body as I had seen five years ago. On questioning him as to his condition during the intervening five years, I found out that on seeing no improvement from rubbings he consulted another physician, who pronounced the disease syphilis and treated him with injections of salicylate of mercury for eighteen months. Seeing no improvement from the injections, he consulted another physician, who, after taking a careful history of the patient's previous unsuccessful treatment, ascribed the disease to some toxæmia and allowed the patient to marry, which he did—having now two healthy children—and treated him with aperients and regulated his diet. But the eruption remained.

On examining him on October 10, I found a longitudinal, soft scar on the thigh, the seat of previous ulceration, and an active new ulceration, looking exactly like the former ulceration on the thigh—in the

right fossa cubitalis. The ulceration started six days ago in the form of an abscess, which opened, leaving the present condition. The ulceration is 2½ m. m. in the transverse direction and 1½ m. m. in the longitudinal. The borders ar raised, slightly infiltrated, and sharply cut. The floor is reddish, granulating, and covered with whitish pus. Slight hardness is felt when pressing in transverse direction. Glands are felt neither in the right axilla, nor in the fossa cubitalis; only in the left axilla is there one perceptible gland. The condition of the skin was the same as shown by the record of five years ago, only more scars could be seen on the lower extremities and some on the trunk. Some of the macules exhibited slight scaling, but on the whole the eruptions looked like the previous one of five years ago. There is a slight dermographism. I present this case as a tuberculide. It has some resemblance to the case I presented a year ago in this section—in which lesions were more advanced.

Dr. Pollitzer said that he believed this case presented two distinct unrelated processes. The macules we are told had persisted unchanged for six years; if they were ever to develop into necrotic papules, they should do so in less time than that. The only change which would produce a macular eruption of this appearance remaining for six years must be a change in the blood vessels. He believed this part of the eruption to be a very slight degree of telangiectasis, congenital, and only accidentally discovered six years ago. This universal macular dermatosis was in no way related to the sparse ulcerated or crusted, probably follicular, lesions. The case in his opinion was one of naevus telangiectodes disseminatus universalis.

Tuberculosis of Testicle and Tuberculide of the Body. Presented by Dr. Lapowski.

The patient is about fifty-six years old. He gives no history of syphilis. Four years ago the patient's right testicle was removed for tuberculosis in Mt. Sinai Hospital by Dr. Goldenberg. For the following two years he felt well. About two years ago he injured the left testicle, and several months later he was taken ill with "pneumonia" and remained in bed for several months, having several hæmorrhages. During his illness the present ulceration of the testicle developed, and has remained since. He came to the Good Samaritan Dispensary complaining of itching of the body. He was weak, lean, emaciated, and coughs with occasional hæmorrhages. On examination a fungate testicle was found and an eruption of various forms scattered over the body. Some are the usual follicular abscesses due to autoinfection, some—especially on abdomen and thighs—are papulo-tubercular in character, with deep necrotic centers and slightly infiltrated borders, leaving scars on healing. Especially on the lower two-thirds of the legs the dark-brownish scars of various dimensions from a pea to quarter-dollar size are very suggestive of a former necrotic process.

The patient complains of severe itching, but there are no marked lesions of pruritus on the body. Tubercle bacteria were found in the sputum. Some of the papulo-tubercles have a striking resemblance to the necrotic papules of the former patient.

Dr. Williams said that without question there was tuberculosis in the lung and in the scrotum, but that the eruption on the skin had no tuberculous character, except its chronicity. There were no hard, deep papules, but on the contrary superficial pustules such as might occur in any mild pus infection.

Dr. Pollitzer agreed with Dr. Williams. A tuberculide should begin deep in the cutis, and then affect the surface; and independently of scratching, it should lead to necrosis and scar formation, whereas the lesions in this case appeared to be infected scratch marks.

Dr. Lapowski, closing the discussion, said that he had observed in this case the firm masses under the lesions, which are so characteristic of a tuberculide.

Vitiligo. Presented by Dr. Trimble from Dr. Fox's service at the Skin and Cancer Hospital.

The patient is a man twenty-four years old, a tailor, and a native of Russia. The case is of interest on account of its resemblance to alopecia areata. The lesions on the neck and sides of the face resemble this latter disease very much, but on closer inspection it can be seen that the hair is present, and it can be easily felt. A number of patches of canities in the scalp would seem to indicate that the vitiligo has been present in these locations also.

THE PHILADELPHIA DERMATOLOGICAL SOCIETY.

The regular monthly meeting of the Philadelphia Dermatological Society was held Tuesday evening, March 17, 1908, at the Medico-Chirurgical Hospital, Dr. M. B. Hartzell, presiding.

Bromide Eruption in an Infant, An Extensive Case of. Presented by Dr. Davis.

The patient was an eight-months-old baby. The eruption first made its appearance after the baby had taken one bottle of a bromide mixture. There were about a dozen patches in all, from split-pea to silver-dollar in size. The lesions were elevated, wart-like, whitish-yellow or brownish in color, sharply marginate, and covered with yellowish-black crusts. A somewhat purulent fluid oozed from some of the lesions, while a whitish-yellow, thick cheesy fluid exuded from others. Several of these individual lesions had coalesced, forming the confluent areas. The lesions were apparent vesicopustules and multilocular. The eruption was noted upon the cheeks, the chin, the trunk, the buttocks, and the lower legs.

The interesting fact was recorded that the lesions continued to appear for twenty-four days after the drug had been stopped.

Tubercular Syphilodermata Resembling Tinea Sycosis. Presented by Dr. Hartzell.

The patient was a male of thirty years, and had noticed the start of this outbreak nine months previously. A small papule first appeared upon the right side of the chin below the lip. This became larger, until at present the patch is silver-dollar in size; it is sharply marginate, raised, papillomatous, reddish, with a serpigenous border, and covered with a somewhat purulent secretion. There is also a quarter-dollar-sized, sharply marginate, raised, somewhat boggy, infiltrated, circinate patch on the right side of the neck below the ear, from which oozes a sticky, purulent fluid. Scars were also present on the chin. Several examinations were made for fungus, but all proved negative. The condition has improved slightly under two weeks' treatment with potassium iodide.

Tinea Favosa Resembling Lupus Erythematosus. By Dr. Davis.

This condition first developed, eight years previously, when the patient was five years old. The girl was born in Hungary. At the present time there are four distinct patches upon the scalp, two silver-dollar in size, and the others dime-sized. The patches are all inflammatory, covered with a fine scale. There is some scarring, but it is chiefly the atrophy of the hair follicles. A great deal of the hair has fallen out, but numerous follicles are still open in the patches and some hair still remains. Because of the erythematous condition, the fact that numerous follicles were unattacked, and the dipping of the scale into the mouths of other follicles, lead to the resemblance to lupus erythematosus. The fungus was demonstrated. No other members of the family had been attacked. It was brought out in the discussion that only rarely was more than one member of a family attacked by this disease.

Lichen Planus Associated with a Probable Palmar Syphilide. Exhibited by Dr. Wallis.

A very interesting condition in a male of fifty-seven years was presented. Apparently the man had two entirely separate and distinct eruptions. Upon the palm of the right hand was a squamous eruption of five years' duration. It was arranged in the form of three incomplete rings, about one-half-dollar in size, the outline was somewhat irregular, the lesions were slightly raised, and had a "plucked-out" appearance, the epidermis being raised and somewhat undermined. He stated that the palmar condition appeared one year after an initial lesion, and that it tended to improve in the summer. The other eruption first appeared six months ago with a few papules upon the wrists. At the present time,

the lesions are found on the flexure surface of the wrists, the back of the hands, the forearms, the elbows, a few scattered papules on the trunk, and on the thighs. The lesions consist of irregularly shaped, reddish-blue, flat, some umbilicated, slightly scaly papules. On the elbows coalescence has occurred, forming palm-sized, scaly, violaceous, slightly raised patches. There is an intense itching and slight burning present. The mucous membranes are uninvolved.

Tubercular Syphilide Resembling Tuberculosis Cutis Verrucosa, A Probable Case of. Presented by Dr. HARTZELL.

The patient was a woman thirty years of age, and had first noted the outbreak seven months ago. Three distinct patches are seen; a thumb-nail-sized lesion is located on the right side of the upper lip, extending on to the mucous membrane; another large somewhat linear patch occupies the entire lower lip, and also part of the chin; a third, three-cent-piece in size, is found on the extreme left hand side of the lower lip. All of the patches are distinctly papillomatous, yellowish-red in color, crusted, and have a slight muco-purulent discharge. The general appearance of the lesions suggested syphillis, blastomycosis, or a tuberculosis. A biopsy was made which showed tissue resembling a tuberculosis, but no tubercle bacilli or blastomyces were found. The lesions are improving markedly under potassium iodide, although the drug has only been administered for a week.

Relapsing Erythema Nodosum. Exhibited by Dr. KATZENSTEIN.

The patient was a girl of seventeen years, and of American parentage. The eruption first started three weeks ago, with the outbreak on the lower legs, of typical erythematous nodes. These nodes were tender, but unusually flat, being scarcely raised above the skin surface, and only slightly infiltrated, with no fluctuation. These lesions involuted in a few days, with the usual color changes. There have been three distinct outbreaks of these nodes, almost macules. At the present time the lower legs show the color changes of a dermatitis contusiformis.

Adenoma Sebaceum, A Probable Case of. Presented by Dr. DAVIS.

The patient was a woman twenty-six years of age, intelligent, and in comfortable circumstances. She had first noticed the spread and growth of these lesions six years ago. At the present there are a hundred or more, closely crowded, confluent and discrete, pin-point to wheat-grain-sized, elevated tumors. These lesions are upon the nose, the adjacent cheeks, and at the inner canthi of the eyes. The tumors are non-inflammatory, yellowish-white, and show glandular orifices. Some milium bodies are also present. The grouping of the lesions resembles somewhat benign cystic epitheliomata. The patient stated that her brother had a few lesions of the same character.

Scleroderma with Purpuric Involvement of the Affected Areas, A Case of. Presented by Dr. Stout.

The patient was a male of fifty-two years. The exact duration of the condition was unknown, although the complicating purpuric outbreak had first started two weeks previously. Both feet, and the entire circumference of the lower legs, extending almost to the knees, were board-like in resistance. The sensation to touch was somewhat impaired, although the patient complained of burning and itching. The feet were of a dusky, dark-bluish hue, but the legs from the ankles to the knees were from a bluish-red to a bright-red in color. Some of the follicles around and below the knee showed pitting.

Lichen Planus, An Extensive Case of. Exhibited by Dr. Stout.

The patient with the eruption was a well-built, healthy male, of twenty-six years. The disease had first appeared six months ago, with a few scattered papules upon the trunk. The lesions are now found on the penis, scrotum, the inner surface of the thighs, the upper legs, and a few scattered papules on the buttocks. There is one continuous patch extending from almost the waistline to the knees, chiefly on the anterior and inner surfaces of the thighs, and the upper legs. The only other lesions consist of a few grouped or single papules on the areas cited. The large plaque consists of numerous confluent, slightly raised, bright-red to violaceous, irregularly shaped, flat, slightly scaly papules. Most of the lesions were almost scarlet in color, and the diagnosis was not clear until a few typical outlying papules were found. The distribution, color, and the very large patch were commented upon. The wrists, the ankles, the entire upper portion of the body, and the mucous membranes of the mouth were free. There was intense pruritus.

Leukoplakia Undergoing Epitheliomatous Change. Presented by Dr. Wallis.

The patient, a male of forty-three years, was an inveterate pipe-smoker. Fifteen years ago a small white patch appeared on the inner surface of the left cheek, just back of the corner of the mouth. This patch slowly increased in size, becoming hard and rough to the touch three years ago. A quarter-dollar-sized, white, papillomatous patch can now be seen on the inner surface of the left cheek, touching the corner of the mouth. Just posterior and joining this lesion is a split-pea sized, ulcerated patch, with a "pearly" border. Upon the inner surface of the right cheek another leukoplakic patch has recently developed. The patient stated that until recently he had always held his pipe on the left side of the mouth. Excision was advised as the proper treatment in the case.

Pigmentation Following the Administration of Arsenic, A Marked Case of. Presented by Dr. SCHAMBERG.

The patient was apparently in good physical condition, although seventy-one years of age. The patient had suffered for some time with a marked pruritus, with no cutaneous lesions. To help this condition, a physician had prescribed large doses of Fowler's solution. About four grains of arsenious acid were taken from the 13th of January to the 13th of February. The entire back from the shoulders to the lumbar region consists of one large, irregularly bordered, yellowish-black, smooth patch. Smaller patches of pigment, of the same character are noted on the chest, the abdomen, and the extremities. The man has a very grotesque appearance, as the patches anteriorly on the body are in a festooned and gyrate arrangement. The man also has numerous large senile warts on the back, between the shoulders, which originated, however, before the arsenic was taken. An excellent Lumiere photograph of the case was exhibited.

Dr. DAVIS showed a specimen of calamin lotion, in which the combination of boric acid with resorcin threw down a red precipitate resembling carmine. Thus forming an accidental and unsightly staining of light-colored hair.

Epithelioma Resembling Syphilis, A Probable Case of. Presented by Dr. PFAEHLER.

The patient was a woman of forty-three years, and had first noticed the lesion eighteen months previously. The woman had originally noted a small, pea-sized swelling, about one inch above the nipple of the right breast, and situated only a little below the skin surface. This increased in size and grew toward the cutaneous surface, forming at last a broken-down, crusted surface with a purulent discharge. The entire mass was exuded, leaving, as at present, a quarter-dollar-sized ulcer, with sharp, punched-out edges, and an uneven base. There is a somewhat inflammatory areolar to the lesion, but only slight induration of the breast. There is dullness in percussion of the mediastinum, and a Roentgen photograph shows a mass in the same area. Because of the general characteristics of the lesion, antisyphilitic treatment was suggested.

Keratosic Eczema of a Possible Neurotic Origin, A Case of. Presented by Dr. SCHAMBERG.

The patient was a woman of thirty years, and of a neurotic temperament. The condition had lasted for six years, improving somewhat in the summer. There were about a dozen lesions in all, located on the index finger and the thumb of the left hand, on the dorsal surface. The lesions were linear in arrangement and seemed to follow the distribution of the digital branch of the radial nerve. The eruption consisted of

raised, rough, flat, wart-like lesions, from split-pea to pinhead in size. There was some fissuring and thickening of the skin, but practically no active inflammation present. The woman complained of sharp, burning pains in the area involved.

Lupus Erythematosus Limited to the Scalp. Presented by Dr. Knowles.

The patient was a woman thirty-two years of age. She had first noticed the start of the eruption twelve years ago. There were four distinct patches in all, from dime to silver dollar in size. The largest area was on the left side of the scalp, above and just in front of the ear, at the hairy-margin. One patch was at the vertex of the scalp, one on the posterior portion, and the last on the right side over the parietal region. The patches were typical in every way, showing the slight scaling, on the inflammatory base, with the patulous follicles, and the scales adherent to these openings. The case was exhibited because the eruption was confined to the scalp, no other portion of the body having been involved at any time. The patient was presented through the courtesy of Dr. Stelwagon.

Dr. Wallis, in closing, showed an excellent photograph of a marked case of steatoma of the scrotum.

Frank Crozer Knowles, M. D.,
Reporter.

MANHATTAN DERMATOLOGICAL SOCIETY.

63d Regular Meeting, November 1, 1907.

Dr. Edward Pisko, Presiding.

Scleroderma of Lower Extremities. By Dr. B. F. Ochs.

Mrs. A. L., fifty-two years old. Two years ago present condition began with burning and smarting of both legs; persistent, and present up to date. Status præsens: Around both ankles and on inner aspects of both thighs is a sharply defined, fine, scaly, itchy, reddened area. Entire skin of the lower extremities is somewhat thickened and glistening. A condition of varicosity of the superficial veins of the lower extremities and vulva is present. This condition extends up to the lower part of the abdomen, the line of demarcation being ill-defined.

Scleroderma of Upper Extremities. By Dr. L. Weiss.

Mrs. M. D., forty-five years old. Twenty-five years ago sustained trauma of left elbow; swelling lasted for one year. No symptoms till one year ago; skin of left arm and forearm became swollen in patches; largest patch on forearm about 12 inches long and 4 inches wide, elliptical in outline; skin is thickened, leathery, not œdematous, red, hot, and the lesion is sharply defined. Similar lesions on arm in small patches and striæ.

Dr. Ullmann believed that some of the patches were beginning to show atrophy.

Atrophia Cutis Idiopathica. By Dr. R. Abrahams.

Mrs. R. S., fifty years old, Russian. Two years ago left leg began to itch; one year later noticed redness of same leg. At same time right leg became red and itchy. One year ago applied to Gouverneur Hospital for relief of the severe itching. General condition was excellent. Skin of both lower extremities was thin, translucent, and wrinkled; veins were prominent and appeared superficial. The affected area was red in color, and had a distinct hyperæmic border. This was observed as each new portion of the skin became atrophic. On each leg, extending anteriorly along the middle third of the tibia, is a patch of sclerotic skin. The atrophic process progressed very rapidly. Within one year both lower extremities, up to the hips, are involved. The interesting feature in this case is that the scleroderma and atrophy appeared at the same time, the former remaining limited to the front of the legs and the latter spreading to its present extent. Patient derives benefit in the exhibition of Thyroid extract, 5 gr. t. i. d., and menthol and carbolic locally.

Dr. Gottheil: Entire lesion is a scleroderma now terminating in atrophy. Dr. Abrahams, in observing the case for one year, always noticed an area of hyperæmia which later terminated in atrophy. Had not seen any scleroderma preceding the atrophy.

Syphilis, Hereditaria Tardia: Rupial and Tubercular General Exanthem. By Dr. W. S. Gottheil.

Willie C., two years old; full-term child, born well. At six months, snuffles, treated as ordinary catarrh; at one year, "spots" over eyebrows, disappearing spontaneously in time; pertussis, from sixth to eighteenth month; measles four months ago; upon recovery, immediately followed by present eruption, which appeared all over the body at once. General condition remained good; head and abdomen always were large. Two other children had measles at same time.

Examination. General eruption, most abundant on back, buttocks, legs, and extensor surfaces of arms. Over a hundred lesions, of the following type, scattered over these surfaces: Small, pinhead to pea-sized, fairly firm, sharply circumscribed, reddish-brown papules, some with very small adherent scales. The very smallest lesions possibly retrogressing, are distinctly of the lichen planus type: flat-topped, more or less angular and shining; the largest ones are prominent rounded tubercles. Over the whole of the back, especially on its upper portion, they have involuted, and are represented by small, circular, sharply cut cicatrices. Three lesions on the palms and one or two on the ears and face. The ears and face are inflamed and evidently secondarily infected. On the backs of the arms the eruption distinctly rupial in type; removal

of the oyster shell-like heaped-up crusts leaves deep, bleeding, and ragged excoriations. Round the anus there are a few hypertrophic papules. The only other sign of heredosyphilis is the presence of enlarged and fairly characteristic inguinal and cervical glands; the epitrochlears are not palpable. The child is rachitic, with enlarged and elongated head and prominent frontal protuberances, etc.

Mother, aged twenty-three, has been five times pregnant: First child, born a year after marriage (17 years old now), is living and well; second child, same; the third is the patient; fourth pregnancy resulted in miscarriage at the fifth month; fifth pregnancy, miscarriage at third month. She has always been well, never had any skin trouble, rheumatism, sores, or discharges. She presents no lesions or remains of lesions, no adenopathy, etc.

Father is said to have had "spots" (reddish-blue in color) on his thighs some few months ago; these were dry and disappeared spontaneously. Otherwise perfectly healthy. He has not been examined.

Dr. Pisko held the lesions to be hæmorrhagic. Dr. Pollitzer in similar conditions had excised large papules and had found large lacunæ filled with blood. Believes the large papules to be angiectatic in character.

Tubercular Syphilide of Nose and Palate. By Dr. Parounagian.

Mrs. M. C., twenty-five, American, chorus-girl; personal history negative; affection began one year ago and has never entirely disappeared. At present lesion consists of a circumscribed crusted patch, covering the upper lip and cartilaginous portion of the nose; crust is thick, yellowish, soft; in groove of upper lip is an atrophic scar, undoubtedly the result of some recent ulceration. The palate is covered with superficial ulcerations and mucous patches; other than a slight adenopathy, no other manifestation of syphilis.

Dr. Pollitzer: Most of the lesions present on the nose were of a purely secondary affair, in all probability infection with streptococcus.

Lichen Planus Verrucosus. By Dr. L. Weiss.

Male, sixty-four; Russian. There are three affected areas, whose characteristics at the present time are almost the same, the duration being different. In the popliteal space the lesion began as a small papule twelve years ago; the one at the sacral region, about four years ago; at present, covering the region of the sacrum and extending outward, so as to occupy about one-third of each buttock, is a violaceous patch with rugose surface (slightly modified by the heat and moisture), with individual lichen papules extending around its periphery. In the popliteal space the lesion is 4 by 6 inches in size. On the left shin are two patches. The larger, sharply defined, circular, about three inches in diameter, shows marked verrucosus changes, is grayish-violaceous, scaly

and indurated; the smaller, one inch in size, is similar; both lesions show a few lichen papules along their peripheries, and have been present one year. Over the lower end of right forearm is a small scaly patch having the same characteristics as those already described. Mucous membranes are clear.

The presenter calls attention to the fact that the verrucous changes in lichen planus appears with predilection on the lower extremities.

Cicatrical Contracture of Unusual Extent Following Late Syphilitic Ulcerations of the Skin. By Dr. W. S. Gottheil.

Male, forty-three; admitted to City Hospital October 10, 1907, suffering from "ulceration" of both elbows. At thirty, acquired "chancre," followed by rash over body; other manifestations not noticed. In early summer of 1907 had "gumma of brain," with subsequent paralysis of left side. During this time (period of three months) had extensive ulcerations of arms, shoulders, and legs. Whilst thus confined to bed, he lay continuously on either side of the body with his arms flexed, so that there was constant pressure on the elbows. This, patient states, is the cause of the ulcerations for which he enters hospital. Gives no history of burn or other accident. Was under the care of a physician in one of the small towns on the Hudson.

Status Præsens: Undersized and poorly developed; remains of hemiplegia are evident, though patient gets around fairly well. Face and greater part of scalp covered with large and small irregular, superficial, white cicatrices, which look as if they dated further back than the summer just passed. These scars are very numerous, with areas of healthy skin (in which the pilous and glandular structures are preserved) between them. Both upper extremities, from beyond the shoulders, clear down to the knuckles, have the skin replaced by an unbroken mass of dense and ridged cicatrical tissue. The shoulder joints are movable; the elbows are held firmly flexed, almost to the extreme, so that the forearms and hands point immovably to each opposite shoulder. Dense and thick cicatricial bands at the elbows keep the arms in this position: bands of lesser extent and thickness keep the hands inflexible. The cicatricial tissue of the left side ends at the middle of that side of the back in a large, circinate, scolloped margin, which curves around several inches below the axilla to the front of the shoulder joint. On the right side the cicatricial tissue does not extend on to the back. On various parts of the back and thighs are large and small circinate smooth cicatrices. The only contractures are in the upper extremities; the only active lesions are on the elbows, the entire points of which are the seats of ulcerations covered with healthy granulations, and evidently closing up.

At the time of the presentation of the patient (November 1, 1907), these ulcerations are nearly cicatrized under ordinary antilectic treat-

ment. For his contractures the patient will be referred to the surgeons.

The presenter states that he has never seen such extreme cicatricial contractures as a conseqcence of serpiginous gummatous ulceration of the skin and subcutis. The whole deformity resembles that occasioned by a severe burn. There is no history of such in this case.

The patient states that up to the beginning of the summer he had no scars of any kind, and that all the lesions now present are the result of what took place during the last summer.

Lichen Planus with Intense Itching. By Dr. E. L. Cocks.

Mrs. M. A., forty-five, has the present eruption for the last five years. Is never free, and the itching is very intense. During first years of the disease arsenic was given till œdema and colic appeared; then protoiodide of mercury, one-sixth of a grain t. i. d.; then corrosive sublimate, one-thirty-second of a grain t. i. d.; no relief. Patient is exhibited for suggestions as to treatment.

Dr. Pollitzer suggested the administration of salicylate of mercury.

Dr. Ochs suggested that the individual lesions be touched with pure carbolic and followed by absolute alcohol.

Dr. Parounagian had used the X-ray with fair success in similar cases.

Xanthoma Tuberosum Multiplex. By Dr. W. S. Gottheil.

John S., twenty-eight; oysterman. Eruption first noticed two years ago. Began at same time on knees, elbows, hands, and buttocks. Individual lesions steadily growing larger, new ones appearing in their neighborhood. Cause no inconvenience; seeks treatment, as the tumors on back of hands interfere with him in his work.

Examination. All the lesions, varying in size from pin-point to small marble, are typical pale yellow, yellowish-pink, and orange colored, prominent, sharply circumscribed masses. Most of these masses are grouped in characteristic locations, but many of them are isolated or scattered over various parts of the body. Both knees are covered with closely aggregated and sometimes confluent smaller tumors; similar condition on the buttocks; elbows less extensively affected, though the individual masses are larger than those on knees or buttocks; on backs of both hands are the largest tumors. The skin on the sides of the chest shows a great number of very small but characteristic xanthomatous masses.

There is no sugar present in the urine.

Psoriasis, on Knees Only; First Attack in Female 52 Years Old. By Dr. M. B. Parounagian.

Since July, 1907, patches on the knees have made their appearance, have not changed, no other lesions appearing anywhere else on the body. Has never had any disease of the skin before these lesions

developed. The lesions are on the extensor surfaces of both knees, circular in outline; the one on the right about half-dollar size; on the left, composed of two lesions, about one-half the size of the one on the right. They are dry, slightly itchy at times, and covered with typical psoriatic scales.

Tuberculide. By Dr. W. S. Gottheil.

Mrs. M. B., forty, married, has four healthy children; never aborted, never sick save for present condition of skin. Two months ago noticed spots on buttocks and upper part of the posterior aspects of the thighs. They have not changed their appearance since that time, nor have they caused her any inconvenience, itching, or pain. One month ago similar spots appeared on elbows and knees, and few isolated ones on the front of the legs and on the calves.

Examination. No abnormality save the dermal lesions; no scars. On knees, elbows, buttocks, calves, and front of the legs are numerous lesions. They are papular and small tubercular tumors, bluish-red in color and sharply circumscribed. Some are covered with central crusts, circular in shape, adherent, and hard and dry. Removal of these crusts leaves a sharply outlined depression, with a dull red, glairy non-exulcerated base. All the lesions are hard, not tender, and extend fairly deeply into the skin. The smaller, more recent ones, have no crusts, but are capped by what appears to be a drying-up vesicle; some show a distinct tendency to umbilication. There are also scattered among the active lesions numerous atrophic, slightly pigmented areas, the bases of which are still slightly hard. These the presenter takes to be cicatrices left by past lesions.

Drs. Cocks and Abrahams were of the opinion that the lesions were those of an acne necrotica.

Favus Capitis, Treated with the X-ray: Cured. By Dr. C. A. Kinch.

Boy, ten years old; was given ten sessions of varying lengths. Now has white scar surrounded by much pigmentation. The scar tissue is due to the long-standing infection with favus, not to the treatment.

Scrofuloderma. By Dr. L. Oulmann.

Girl, 13 years old. Was well up to five years ago; at that time was vaccinated, which was followed by a general adenopathy, and has been feeling poorly ever since. Six months ago swellings appeared around the ears and in the sub-maxillary region and were very tender. Two weeks later these swellings broke down and discharged a large amount of pus. This discharge is still present.

Status præsens: Entire skin of sub-maxillary region is affected. There are a number of ulcers varying in size from one-half to four

inches. Walls are inflamed, irregular, bases are necrotic, the larger lesions having broken-down glands as portions of their bases. Over right clavicle is a swelling, with the skin over it reddened and œdematous.

The microscopical examination of a section of a gland shows the presence of tubercles, giant cells, and tubercle bacilli.

The presenter is of the opinion that the necrotic process present is not the result of the tubercular infection alone, but of a mixed infection with pus organisms.

Early Secondary Syphilis with Late Manifestations. By Dr. M. B. Parounagian.

Male, Armenian, thirty-nine, single. Consulted physician in August on account of itching in region of anus. Upon examination hemorrhoids and a superficial ulceration of the right gluteal ridge was found. Further examination revealed a general adenopathy. Patient was put upon anti-leutic treatment. Readily responded, but at end of one month, contrary to advice, stopped treatment. Three weeks later throat became sore, mucous patches appeared upon the lips and tongue, and a papular reddish eruption appeared on the chin, nose, and forehead; also an ulceration upon the palate. Under Ungt. Hydrar. Ammon. the lesions disappeared, except the one on the palate. The case is presented to show that while the lesions upon the skin were clearly of a secondary nature, the lesions in the mouth were distinctly tertiary.

Morphoea. By Dr. L. Oulmann.

Male, Russian, forty-three. In February of this year patient noticed a small purplish patch on left side of abdomen, in the axillary line. The patch is continuously growing larger. Its color gradually changed to cream. It is now about the size of the palm, hard, not attached to the deeper parts, and has an erythematous raised margin.

The presenter has used the X-rays on this lesion up to the present time with no apparent result.

M. B. Parounagian, M. D.,
Secretary.

MANHATTAN DERMATOLOGICAL SOCIETY.

64th Regular Meeting, December 6, 1907.

Dr. A. Bleiman, Chairman.

Chancre of the Anus. By Dr. B. F. Ochs.

Boy, sixteen years old. Three months ago, while in a lodging house, a man attempted intercourse with him per rectum. About three weeks later he noticed a sore on his anus. At first the lesion was itchy, and in a few days there was marked ulceration. After waiting a few weeks he applied for treatment.

Examination. On the left side of the anus is an irregular mass three-quarters by three inches in size, elevated, grayish, border somewhat darker and firmer than the mass itself. On the right side of the anus are smaller, similar masses. There is also a general macular eruption, general adenopathy, and a specific angina. Under anti-syphilitic treatment the eruption has disappeared and the masses have grown considerably smaller.

Granuloma, Due to Strepto- and Staphyococcus Infection. By Dr. B. F. Ochs.

Female, sixty-three years old. Last June accidentally stuck the thumb of her right hand with a brass pin. For a week the finger was sore and painful, then noticed a small tumor growing from the place of entrance of the pin. Excised at dispensary, base cauterized, and a wet dressing applied. In a short time the growth reappeared, but as it caused her no pain, she did nothing for it.

On November 5, 1907, she applied to the Lebanon Dispensary for treatment. On the outer side of the end phalanx of the thumb of the right hand was a hemispherical, perfectly smooth, dark red, soft mass, about the size of a cherry, entirely without skin, on a non-inflammatory base. No tenderness, no itching. The mass was excised, base cauterized, and a wet compression dressing applied. In a week the mass had returned and was much larger and was somewhat painful. On account of the rapidity of the return of the mass, a diagnosis of angiosarcoma was made. The mass was excised, a large portion of non-affected skin was removed with it, and a firm dressing applied. No recurrence.

Microscopical examination showed the mass to be composed of granulation tissue, in the meshes of which were large numbers of staphyo- and streptococci. Diagnosis: Inflammatory granuloma.

Radio-Dermatitis. By W. S. Gottheil.

Mrs. M. S., thirty-one years old. In June, 1907, had both forearms rayed twelve times for hypertrichosis by a radiotherapeutic expert. At first, daily; later, every other day. After the twelfth session an intense redness, later a purplish discoloration accompanied by a severe burning pain was noticed. Two weeks later vesiculation and ulceration followed. Patient was then referred to the presenter.

Present condition: Left Forearm—On dorsal aspect are two ulcerations, the larger about 5 by $1\frac{1}{2}$ inches in size, the smaller about the size of a silver dollar; there is some granulation tissue present. The edges are red, somewhat raised, and firm.

Right Forearm—In the corresponding position is a smaller, though healthier, lesion. Both lesions emit a foul odor. Since their appearance they have been treated according to surgical principles with little effect.

The upper margin of the lesion on the left forearm shows some cicatrical tissue. The case is presented for suggestions as to treatment.

Dr. Geyser advised the use of blue light for the pains, and dry dressings for the ulcerations. Dr. Gottheil remarked that these cases interested him very much, as he had seen a number of them, sent to him by physicians who had applied the rays very carefully and for a short time, with disastrous results. He does not consider the ulcerations as burns proper, but as aseptic necrosis, which condition does not respond very readily to the treatment at our disposal.

Case for Diagnosis. By Dr. B. F. Ochs.

J. S., forty-three, sailor. Had been under observation of Health Board for supposed variola, and discharged as not being a true case. Then developed pneumonia; was sick for three weeks. After leaving hospital found that his entire skin was desquamating.

Examination: On the scalp some slightly depressed, whitish, well-defined areas, surrounded by a line of fine desquamation. On the body the scales are somewhat larger, desquamation irregular, some parts of the body being free. On the hands and feet the exfoliation is in large flakes. On the body are some few isolated light brownish to dark brownish non-elevated spots, varying in size from pinhead to lentil; the entire skin is thickened, especially the palms.

The patient's occupation at present is that of a stone-cutter.

Drs. Gottheil and Parounagian were inclined to erythema multiforme, on account of the apparent remains of vesicles now present. Drs. Kinch and Robinson favored some drug eruption complicated by some general erythematous lesion.

Primary Sclerosis Coincident with Condylomata. By Dr. B. F. Ochs.

Girl. eighteen, colored, presents around vulva a number of lesions. Directly in the center of the fourchette is a hard and sharply defined ulcer, with sloping edges and undermined base. Surrounding this are a number of condylomata, soft, and non-inflammatory, which also extend up around the vulva.

Lichen Planus Limited to One Hand. By B. F. Ochs.

E. W., twenty. Always well up to one year ago, when small "warts" appeared on back of right hand. Slowly these increased in number, so that at the present time the entire dorsum of the right hand is fairly studded with these lesions. They are small, shiny, grandular, flat papules, many with depressed centers, violaceous in color. On the face, under left lower lip, is a sharply defined area of scaly eczema.

The case is presented on account of the isolated patch of lichen planus.

M. B. Parounagian, M. D.,
Secretary.

REVIEW
of
DERMATOLOGY AND SYPHILIS

Under the charge of A. D. Mewborn, M. D.

INFLAMMATIONS.

By H. P. Towle, M. D., Boston.

Erythema Nodosum, Arthritis and. Symes. *Brit. Med. Jour.*, 1907, 2, p. 202.

The article begins with the statement that the generally accepted view with regard to the arthritis which sometimes accompanies erythema nodosum is that it is a true articular rheumatism. To this view Symes dissents. He also maintains that, according to his experience, the association of arthritis is less frequent than is commonly stated. He could not obtain the signs or the history of chorea, endocarditis or arthritis in more than ten per cent. of all his cases. His reasons for believing that the arthritis of erythema nodosum is not a true rheumatism are—that, unlike rheumatic fever, erythema nodosum is most common in females; is most prevalent in the last and first two quarters of the year; has a long prodromal period of malaise; comparative freedom from recurrence; slight constitutional disturbances during the period of fever; is characterized by phlyctenulæ in the eyes; the arthritis, the fever and the rash are but slightly influenced by the salicylates. He then quotes three cases to illustrate these points.

Erythema Nodosum, Upon the Etiology of. Hildebrandt. *Münch, Med. Wochenschr*, 1907, LIX, 310.

Hildebrandt reports a case in support of the statement made by Uffelmann and Oehme that a relationship exists between tuberculosis and certain forms of erythema nodosum. The patient was a woman, aged 24, who had been tuberculous since childhood. The present affection is recent and came on ten or twelve days after an acute attack of angina and stomatitis. At the time the erythema nodosum was at its height, when new eruptions were appearing every day, a positive diazo-reaction was obtained. Two guinea pigs which received intraperitoneal injections of venous blood taken from the patient at this time developed tuberculosis. The search for other bacteria in the venous blood was negative. Later on the patient developed in succession a right-sided pleurisy, then a left-sided pleurisy and finally a pericarditis, together with an infiltration of the right apex, all of which were considered to be tubercular. It is also stated that at the very time the erythema nodosum was in its most active stage virulent tubercle bacilli were found in the blood. Hildebrandt's conclusions are that, while an erythema nodosum which occurs in a tubercular patient may not necessarily have any connection with the tubercular

process, yet it is very possible, if not actually proved, that the tubercle bacilli may provoke an eruption which can not be distinguished from the ordinary erythema nodosum.

Psoriasis, Three Cases of, in Infants. Friedrichs. *Derm. Zeitschr.*, 1907, XIV, 232.

Friedrichs reports three unusual cases of psoriasis in infants in which, however, he admits that the diagnosis is not beyond dispute. The point upon which he apparently lays the greatest stress in making his diagnosis is the presence of capillary bleeding upon irritation.

Case I—Three months old. The eruption began two weeks before in the axillæ and popliteal spaces. Thence it gradually spread over the body until it had become almost universal, only the hands, feet and a few small strips on the body being spared. The borders of the eruption toward these free places were polycyclic. The affected skin was red and covered with small and large laminated scales, especially abundant on the scalp. On the outer sides of the forearms were raised lesions whose centres were covered with heaped-up scales and which showed typical capillary bleeding on scratching.

Case II—Eight weeks old. The skin of the lower half of the body up to the navel was diffusely red and covered with fine scales. Removal of the scales induces capillary bleeding. Upon the upper half of the trunk and on the scalp were larger, disc-form and smaller, somewhat raised lesions, covered with silvery scales, which showed capillary bleeding upon scratching.

Case III—Three months old. The eruption had been present ever since the child was one and one-half months old. The parts involved were the scalp, neck, lower abdominal region, buttocks, scrotum and adjacent parts of the thighs. These areas were intensely red, somewhat infiltrated and partially covered with scales. The borders toward the sound skin were polycyclic and sharply defined. Scattered over the sound skin nearby were small lesions covered with whitish, shining, easily-detached scales. Capillary bleeding. Pruritus marked.

Urticaria, Treatment of. Finch. *N. Y. Med. Rec.*, Feb. 22, 1908, p. 301.

Finch prefers creosote in the treatment of urticaria, although he can not explain its action. Under its use he has seen cases which had resisted all ordinary treatment clear up after a few doses. He believes that an attack may be greatly modified or even averted in acute toxic cases if they are seen early, before the eruption is fully developed. Finch administers four minims of creosote in elastic capsules with two minims in an enteric pill as an initial dose, followed every fifteen or twenty minutes by two minims in capsules until effect. In the recurrent or chronic forms

of urticaria also creosote may lessen the frequency of the attacks or cause them to cease entirely. Two minims are given in capsules after each meal and before retiring, and four minims in an enteric pill. He reports one case of nine years' duration in which this treatment has been followed for five years. Whereas the attacks were formerly frequent, since taking this treatment the patient has often had weeks and months without one. In violent cases he advises the administration of five grains of Turpeth mineral mixed with a little water to induce emesis, giving a high enema at the same time. If the enema fails, he gives a single dose of atropine, four-one hundred and fiftieths grain subcutaneously. In cases with œdema of the mucous membranes the inhalation of amyl nitrite is advised together with the local application of adrenalin.

Lichen Ruber Verrucosus of the Scalp, A Case of. Arndt. *Derm. Zeitschr.*, 1907, XIV, 122.

Before the Berlin Dermatological Society Arndt demonstrated a case of this very unusual condition of which, according to Arndt, but seven or eight cases have been reported. In the present case an itching eruption had existed behind the left ear and in the adjacent hairy scalp for a year and a half. Although the situation was unusual, Arndt considered that the diagnosis of lichen ruber verrucosus was easy. The eruption consisted of a plaque immediately behind the ear which was made up of a number of split-pea sized, yellowish-white, "horn-cyst" lesions, while, further back, were comedo-like formations with black tops situated about the mouths of the follicles.

Lichen Planus, A Case of Syphilis with. Arndt. *Derm. Zeitschr.*, 1907, XIV, 123.

Six days after the completion of a series of injections given in treatment of a secondary syphilide, a non-itching eruption developed on the skin of the penis and scrotum, about the navel, lower abdomen and on the dorsum of the left hand. Close inspection proved the eruption to be a typical lichen planus. The lesions were typical grayish-white, miliary, hemispherical papules occurring both singly and in groups and also larger bluish-red discs, some of which were covered with very dry, adherent scales. Some were arranged in rows and in a net-work after the characteristic manner of lichen planus. This arrangement was of diagnostic importance to Arndt in differentiating the eruption from a manifestation of syphilis.

Psoriasis, Treatment of, by Ultraviolet Rays. Becker. *Deutsche Med. Wochenschr.*, 1907, XXXIII, 2139.

Becker reports good results from the treatment of psoriasis by the ultraviolet rays. He does not believe it necessary to press the lamp

directly down upon the patches if they are not infiltrated as he was able to obtain his results with lamp at a distance. This method allows larger areas to be exposed than if the lamp is close. Becker filtered the rays through a solution of methylene blue, fixed the lamp at from 5 to 15 cm. and gave sittings of from 5 to 15 minutes' duration every second day. The ideal reaction, he states, is a simple hyperæmia without vesiculation. For infiltrated plaques, he advises the conjoined use of the x-rays.

Pityriasis Rubra Hebrae, Pemphigus Foliaceus and Dermatitis Herpetiformis of Duhring. Bogolepoff. *Archives de Med. Experimentale et d'Anat. Path.*, 1907, XIX, 705.

Bogolepoff had the opportunity to perform autopsies on two patients with pityriasis rubra Hebræ, one with pemphigus foliaceous and one with dermatitis perpetiformis Duhring. He was much impressed by the fact that alterations in the thyroid glands and in the suprarenal capsules were present in all four cases. While he does not wish to assert that alterations in these glands is the sole cause of these diseases in all cases, yet he believes that many cases may perhaps be referred to them. He therefore publishes the cases in the hope that they may lead to further investigations by others.

At autopsy Bogolepoff found the following pathological changes:

Case I—Pityriasis rubra Hebræ. Atrophy of the thyroid body with colloid material in the follicles.

Case II—Pityriasis rubra Hebræ. Colloid degeneration of the thyroid body with increase of connective tissue. Metastatic nodule of lymphosarcoma in supra-renal capsule.

Case III—Pemphigus foliaceus. Adenoma of thyroid body. Adenoma of suprarenal capsule.

Case IV—Maladie de Duhring. Adeno-carcinoma of thyroid body. Degenerative vacuole formation and connective hyperphasia of suprarenal capsule.

The argument which lead him to believe that pathological changes in the thyroid and the supra-renal capsules may have an ætiological relationship to these affections may be summarized as follows: Experimental physiology has shown that extirpation of either the thyroid or the suprarenals gives rise to symptoms of poisoning, although the actual toxin is not known. As the symptoms following the extirpation of the thyroid resemble those arising from the extirpation of the suprarenals, the conclusion that the two glands possess analogous functions seems justified. The exact nature of these functions, however, still remains uncertain. In the case of the thyroid, the prevailing belief is that it is the production of iodothyrine which is supposed to neutralize the toxic effects of nitrogen products which accumulate in the blood. It is also known that pathological changes in the thyroid tend to produce

myxœdema or Basedow's disease on the one hand or symptoms of intoxication on the other; while pathological changes in the suprarenals, such as tuberculosis, accompany Addison's disease on the one hand, although not invariably, and symptoms of poisoning, like those of curare, on the other. Various affections of the suprarenals have been found in connection with Addison's disease, such as tuberculosis, cancer, amyloid, cysts, gummata and abscesses. Oro has also demonstrated by autopsy the presence of atrophy of the suprarenal capsules in subjects with an erythrodermie exfoliante. In this disease, moreover, Brocq has called attention to the fact that in cases which recover the last symptom to disappear is the pigmentation and that the degree of this pigmentation varies directly with the degree of the preceding redness. In view of these facts, Bogolepoff believes that this pigmentation as well as the desquamative appearances are provoked by changes in the suprarenals.

Much confusion also exists in regard to the etiology of pemphigus and dermatitis herpetiformis, although the majority refer the cause to some change in the nervous system. Bogolepoff asks how, in this case, the changes which he found in the thyroid are to be explained. He believes that they are the cause of pemphigus foliaceus and of dermatitis herpetiformis. His reasoning is that the first result of the pathological alterations in the thyroid is an interference with the production of iodothyrine. Now iodothyrine, he says, increases the excitability of the pneumogastric and depressor nerves which regulate the force and frequency of the contractions of the heart and at the same time it diminishes the excitability of the vaso-motor and accelerator nerves. As a result of the interference with the production of iodothyrine iodine accumulates in the organism, changes occur in the cardiac and vaso-motor nerves and all the symptoms of oidine poisoning and vaso-motor disturbance follow. That bullous eruptions may follow iodine poisoning is attested by numerous writers. Therefore, Bogolepoff concludes, pemphigus foliaceus and dermatitis herpetiformis are forms of iodine poisoning induced by pathological changes in the thyroid.

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